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THE MEDICAL PRIVILEGE IN THE FEDERAL COURTS—SHOULD IT MATTER WHETHER YOUR EGO OR YOUR ELBOW HURTS?

*Kenneth S. Broun**

The landmark case of *Jaffee v. Redmond*¹ set the parameters for a medical privilege in the federal courts. Before *Jaffee*, some,² but not all,³ federal courts recognized a psychotherapist-patient privilege. The law was clearer with regard to the non-existence of a general physician-patient privilege—all of the federal courts, at least in recent years,⁴ rejected such a privilege.⁵

* Henry Brandis Professor of Law, University of North Carolina School of Law. Some significant parts of the research for this article were done in connection with the author's work as a consultant to the Federal Rules of Evidence Advisory Committee. This research was embodied in memoranda prepared for committee. However, the views and opinions expressed in this article are those of the author and not necessarily those of the Advisory Committee or any individual member of that committee. The author wishes to thank Professor Daniel J. Capra for his reading and helpful comments on an earlier draft of this article. The views and opinions expressed are the author's and not necessarily Professor Capra's.

1. 518 U.S. 1 (1996).

2. See, e.g., *In re Doe*, 964 F.2d 1325, 1328–29 (2d Cir. 1992) (finding a qualified psychotherapist-patient privilege exists); *In re Zuniga*, 714 F.2d 632, 640 (6th Cir. 1983) (finding the privilege exists but does not apply to identity or fact and time of treatment).

3. *United States v. Burtrum*, 17 F.3d 1299, 1302 (10th Cir. 1994) (refusing to recognize a psychotherapist-patient privilege in a criminal child sexual abuse case); *In re Grand Jury Proceedings*, 867 F.2d 562, 565 (9th Cir. 1989) (finding no psychotherapist-patient privilege in a federal criminal case); *United States v. Corona*, 849 F.2d 562, 567 (11th Cir. 1988) (finding no physician-patient or psychotherapist-patient privilege exists in federal criminal trials).

4. Professors Charles Alan Wright and Kenneth Graham take the position that the federal authority rejecting the privilege is not totally clear. See 25 CHARLES ALAN WRIGHT & KENNETH L. GRAHAM, FEDERAL PRACTICE AND PROCEDURE § 5522, at 68 (1989).

5. See, e.g., *Hancock v. Dodson*, 958 F.2d 1367, 1373 (6th Cir. 1992); *United States v. Moore*, 970 F.2d 48, 50 (5th Cir. 1992); *United States v. Bercier*, 848 F.2d 917, 920 (8th Cir. 1988); see also *Post-Jaffee* cases: *Boddie*

After *Jaffee*, there is a psychotherapist-patient privilege in the federal courts, and it is absolute. There is just as clearly no general physician-patient privilege.

The Court in *Jaffee* recognized a psychotherapist-patient privilege and applied it to confidential communications to a licensed social worker.⁶ The Court's rationale was utilitarian: the privilege serves the public interest by facilitating the process of appropriate treatment for individuals suffering from a mental or emotional problem.⁷ The Court noted:

Effective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.⁸

The Court was careful to reject any notion that the privilege be qualified by a balancing component: "Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."⁹

Communications to a psychotherapist were distinguished from those made to a physician for physical ailments where "[t]reatment . . . can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests."¹⁰

This article will explore whether the medical privilege in the

v. Cranson, No. 97-3247, 1999 U.S. App. LEXIS 8742 (6th Cir. May 4, 1999); *Martin v. Cottrell Contracting Corp.*, No. 7:00-CV-114-F(1), 2000 WL 33177232 (E.D.N.C. Sept. 13, 2000).

6. *Jaffee*, 518 U.S. at 10.

7. *Id.* at 11.

8. *Id.* at 10.

9. *Id.* at 17.

10. *Id.* at 10.

federal courts should be expanded beyond the psychotherapist-patient privilege to a broader, more general physician-patient privilege such as that existing in more than forty states.¹¹ It will conclude that the Court's distinction between statements made for the purpose of mental as opposed to physical ailments is not justified and that a privilege, limited in scope to the communications covered by the presently existing and relatively narrow psychotherapist-patient privilege, is justified. Such a privilege would be applicable in relatively few cases, but its existence may be important in some instances, and the policy that it symbolizes is significant for the protection of basic privacy rights.

Part I of this article sets out the parameters of the psychotherapist-patient privilege as it has developed in the federal courts since the *Jaffee* case. Part II discusses the arguments for and against a broader medical privilege. Part III discusses the impact that a broader privilege would have had on existing cases. Finally, Part IV proposes an extension of the privilege to cover the same kinds of communications that are covered by the psychotherapist-patient privilege.

I. THE PARAMETERS OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE.

A. *Rules of Reference: Proposed Federal Rule 504 and Uniform Rule of Evidence 503*

As originally drafted in 1969,¹² revised in 1971,¹³ and sent to Congress by the United States Supreme Court in 1972,¹⁴ the Proposed Federal Rules of Evidence contained nine rules governing specific privileges. Among those rules was Rule 504, governing

11. For a complete list of the states using a more general physician-patient privilege, see *infra* note 160.

12. Kenneth S. Broun, *Giving Codification a Second Chance—Testimonial Privileges and the Federal Rules of Evidence*, 53 HASTINGS L.J. 769, 772-79 (2002); FED. R. EVID. 5-01 to 5-13 (Preliminary Proposed Draft Mar. 1969), 46 F.R.D. 161, 243-84 (1969).

13. Broun, *supra* note 12 at 772; FED. R. EVID. 5-01 to 5-13 (Revised Proposed Draft Mar. 1971), 51 F.R.D. 315, 356-83 (1971).

14. Broun, *supra* note 12 at 772; FED. R. EVID. 501-513 (Version Promulgated by U.S. Supreme Court Nov. 20, 1972), 56 F.R.D. 183, 230-61 (1973).

communications between psychotherapists and patients.¹⁵ All of the

15. FED. R. EVID. 504 (Version Promulgated by U.S. Supreme Court Nov. 20, 1972), 56 F.R.D. 183, 240 (1973):

(a) Definitions.

(1) A "patient" is a person who consults or is examined or interviewed by a psychotherapist.

(2) A "psychotherapist" is (A) a person authorized to practice medicine in any state or nation or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.

(3) A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

(b) General rule of privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition, including drug addiction, among himself, his psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.

(c) Who may claim the privilege. The privilege may be claimed by the patient, by his guardian or conservator, or by the personal representative of a deceased patient. The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority so to do is presumed in the absence of evidence to the contrary.

(d) Exceptions.

(1) Proceedings for hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

(2) Examination by order of judge. If the judge orders an examination of the mental or emotional condition of the patient, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.

(3) Condition an element of claim or defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of

privilege rules, including Rule 504, were rejected by Congress in its enactment of what are now the Federal Rules of Evidence¹⁶ and replaced by Rule 501, providing that testimonial privileges in cases applying federal law “shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.”¹⁷ State rules of privilege are to control all federal cases governed by state law.¹⁸

The controversy over the enactment of the Federal Rules of Evidence centered largely on the privilege rules.¹⁹ Among the many objections to the proposed rules was a strenuous objection to Rule 504 and its limitation of the medical privilege to communications between psychotherapists and patients.²⁰ Many commentators decried the failure of the proposed rules to recognize the privilege that existed in a significant majority of the states protecting communications between patients and physicians generally.²¹ In the end, Congress decided to stay out of the controversy entirely and to leave the development of the law of this privilege and all other evidentiary privilege to the federal common law.²² Indeed, its fear of

his claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.

16. NOTES OF COMMITTEE ON THE JUDICIARY, H.R. REP. NO. 93-650, FED. R. EVID. 501 app.

17. FED. R. EVID. 501.

18. *Id.*

19. For discussions of the controversy in Congress over the privilege rules see Broun, *supra* note 12 at 779; Edward J. Imwinkelried, *An Hegelian Approach to Privileges Under Federal Rule of Evidence 501: The Restrictive Thesis, the Expansive Antithesis, and the Contextual Synthesis*, 73 NEB. L. REV. 511, 517-23 (1994); Thomas G. Krattenmaker, *Interpersonal Testimonial Privileges Under the Federal Rules of Evidence: A Suggested Approach*, 64 GEO. L.J. 613, 638-46 (1976).

20. See Broun, *supra* note 12 at 776.

21. See, e.g., Charles L. Black, Jr., *The Marital and Physician Privileges—A Reprint of a Letter to a Congressman*, 1975 DUKE L.J. 45, 49-51 (1975); John Hart Ely, *The Irrepressible Myth of Erie*, 87 HARV. L. REV. 693, 694 (1974); *Hearings Before the Special Subcomm. on Reform of Fed. Criminal Laws of the Comm. on the Judiciary House of Representatives, 93d Congress*, 158, 160 (1973) (testimony of Charles R. Halpern and George T. Frampton, Jr. on behalf of the Washington Council of Lawyers, Proposed Rules of Evidence); *Id.* at 203-05 (testimony of George S. Leisure on behalf of the New York Trial Lawyers Committee, Proposed Rules of Evidence).

22. Broun, *supra* note 12 at 769-70.

venturing into the privilege morass was so great that Congress specifically provided that enactment of privilege rules required affirmative congressional action as opposed to the ordinary rule making procedure.²³ The law of privilege would either have to be developed on a case-by-case basis in the courts or by statute.

Despite the Congressional rejection of the draft rule governing a psychotherapist-patient privilege, the Court in *Jaffee* referred to Proposed Rule 504 as supportive of its decision.²⁴ The Court noted the statement of the Senate Judiciary committee that its action in rejecting the proposed rules “should not be understood as disapproving any recognition of a psychiatrist-patient . . . privileg[e] contained in the [proposed] rules.”²⁵ Not surprisingly, the case law following *Jaffee* has been largely consistent with Proposed Rule 504. Following that rule can be a useful guideline in looking for the parameters of the federal law on the issue.

Another general reference for a medical privilege is Uniform Rule of Evidence 503 as last amended in 1999.²⁶ This model rule is based upon Proposed Federal Rule 504, but has been modified to include the provision of an option that would apply the rule to communications to physicians generally as well as to psychotherapists or “mental health provider[s].”²⁷

The general state of the law governing the medical privilege in the federal courts can be gleaned from the Proposed Federal Rule 504. There are, however, some important additional issues that have been decided by the courts with regard to the privilege that provide some gloss on the rule and that are especially significant in considering the possible application of the privilege beyond communications for treatment of mental conditions. The remainder of this section deals with such issues.

23. Any “rule creating, abolishing, or modifying an evidentiary privilege” must be approved by an Act of Congress. 28 U.S.C. 2074(b) (1994).

24. *Jaffee*, 518 U.S. at 14–15.

25. *Id.* (quoting S. REP. NO. 93-1277, at 13).

26. UNIF. R. EVID. 503.

27. *Id.*

B. The Privilege Extends to Notes and Records if They Reflect Communications.

The Court in *Jaffee* referred to the need to protect “confidential communications” and relied on the need for an “atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories and fears.”²⁸ Based on these considerations, the Court went on to protect the social worker’s notes as well as her recollection of the communications from the patient.²⁹ In *Jane Student 1 v. Williams*,³⁰ the court included notes made by a psychotherapist in privilege communications. In addition, the court protected information from conversations between patient and psychotherapist where the notes are prepared by someone other than the psychotherapist, “as long as the third person’s receipt of the information does not destroy confidentiality and thus the privilege[.]”³¹

C. Does the Privilege Apply Beyond the Licensed Psychotherapist?

Proposed Federal Rule 504(a)(2) defined psychotherapist as: (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.³²

Jaffee applied the privilege to a licensed social worker.³³ Based on *Jaffee* and the Proposed Rule, communications to any licensed mental health provider would clearly seem to be included within the privilege.³⁴ It also seems clear that a physician, including a general practitioner, would be covered by the privilege, providing that he or she were dealing with a mental, as opposed to a physical health issue.³⁵ Not fully resolved by the federal courts is the extent to which unlicensed persons providing mental health services are to be

28. *Jaffee*, 518 U.S. at 10.

29. *See id.* at 18.

30. 206 F.R.D. 306, 310 (S.D. Ala. 2002).

31. *Id.* at 310.

32. FED. R. EVID. 504(a)(2) (Version Promulgated by U.S. Supreme Court Nov. 20, 1972), 56 F.R.D. 183, 240 (1973).

included in the privilege as established in *Jaffee*. The Court in *Jaffee* used the term “licensed” in referring to the social worker to whom the communications were made,³⁶ but that was the only fact scenario before the Court. Proposed Rule 504(a)(2) used the term “authorized,”³⁷ language that is broad enough to include someone who is authorized but unlicensed.

Some federal courts have applied the privilege to communications to unlicensed persons. In *Oleszko v. State Compensation Insurance Fund*,³⁸ the court applied the privilege to unlicensed counselors employed by an Employee Assistance Program (“EAP”). The court found an analogy to the licensed social worker in *Jaffee* stating:

EAPs, like social workers, play an important role in increasing access to mental health treatment. . . . Growing numbers of EAPs help employees who would otherwise go untreated to get assistance. The availability of mental health treatment in the workplace helps to reduce the stigma associated with mental health problems, thus encouraging more people to seek treatment. EAPs also assist those who could not otherwise afford psychotherapy by providing and/or helping to obtain financial assistance.³⁹

The court went on to note that the EAPs in question worked as part of a team with licensed psychologists or social workers.⁴⁰ It is, therefore, possible that the court would have reached a different conclusion if the EAPs’ work had not been done in connection with licensed persons.⁴¹ Nevertheless, the court’s language, together with

33. *Jaffee*, 518 U.S. at 15.

34. UNIF. R. EVID. 503 provides an optional term “mental-health provider” as the recipient of the privileged communications. Part (a)(2) defines “mental-health provider” as a “person authorized, in any State or country, or reasonably believed by the patient to be authorized, to engage in the diagnosis or treatment of a mental or emotional condition, including addiction to alcohol or drugs.”

35. *See, e.g.*, *Finley v. Johnson Oil Co.*, 199 F.R.D. 301, 303 (S.D. Ind. 2001) (holding the privilege applies to communications to general practitioners dealing with mental health issues).

36. 518 U.S. at 15.

37. 56 F.R.D. at 240.

38. 243 F.3d 1154, 1156–57 (9th Cir. 2001).

39. *Id.* at 1157–58.

40. *Id.* at 1158.

41. *Id.* Analogizing to statements made to agents of either the lawyer or the

similar rulings in some District Court cases,⁴² is broad enough to suggest that the broader term “authorized” as used in Proposed Rule 504 may be the guiding principle.

At least one Court of Appeal has applied a less generous definition of psychotherapist than did the court in *Oleszko*, although under circumstances that are distinguishable. In *United States v. Schwensow*,⁴³ statements to Alcoholics Anonymous volunteer telephone operators were not protected. The court noted that the operators did not possess credentials that might qualify them as “licensed.”⁴⁴ In *Schwensow*, however, the court relied on other facts that prevented the application of the privilege and might well have prevented its application even if the operators had been fully licensed.⁴⁵ The operators did not identify themselves as therapists or counselors.⁴⁶ They did not confer with the defendant in a fashion

client in the context of the attorney-client privilege makes it likely that such communications would be covered. *See, e.g.*, *United States v. Kovel*, 296 F.2d 918, 921 (2d Cir. 1961) (finding that attorney-client privilege extended to an accountant hired by an attorney to aid the attorney in understanding the client’s financial situation); *Winchester Capital Mgmt. Co. v. Mfrs. Hanover Trust Co.*, 144 F.R.D. 170, 172 (D. Mass. 1992) (holding that privilege extended to principal of corporate client where disclosure by attorney was reasonable and necessary). Courts dealing with psychotherapist-patient privilege have also had no problem extending the privilege to persons who are clearly agents of the psychotherapist. *See, e.g.*, *Jane Student 1*, 206 F.R.D. at 310 and *supra* note 30. Furthermore, Proposed Rule 504(a)(3) provided that:

[a] communication is “confidential” if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient’s family.

42. *Greet v. Zagrocki*, No. CIV. A. 96-2300, 1996 WL 724933, at *1 (E.D. Pa. Dec. 16, 1996) (privilege protects files with regard to police officer’s consultation with department’s Employee Assistance Program. The consultation was with regard to department’s “in-house alcohol dependency program.”); *United States v. Lowe*, 948 F. Supp. 97 (D. Mass. 1996) (communications to unlicensed rape crisis counselor privileged. The victim waived the privilege to a limited extent by agreeing to an *in camera* review of records).

43. 151 F.3d 650, 657–58 (7th Cir. 1998).

44. *Id.* at 657.

45. *Id.* at 657–58.

46. *Id.* at 657.

that in any way resembled a psychotherapy session.⁴⁷ There was no indication that the AA office provided counseling service.⁴⁸ The telephone calls in question were made for the purpose of finding out the address of a detoxification center, not for help in coping with alcoholism.⁴⁹ Finally, the court stated that the interactions did not relate to diagnosis, treatment or counseling and “[u]nder no circumstances [could] these communications be interpreted as ‘confidential communications’ entitled to protection from disclosure”⁵⁰

One District Court has more specifically rejected the language in *Oleszko*. In *Jane Student 1 v. Williams*,⁵¹ the court held that licensed counselors were covered by the privilege, but unlicensed counselors were not. The court specifically rejected the reasoning of *Oleszko* based, in part, upon the language in *Jaffee* applying the privilege to “licensed” social workers.⁵² The court also believed that there needed to be a brighter line for the boundaries of the privilege than would exist if unlicensed mental health providers were included.⁵³ The court noted that all but eight states recognizing a social worker privilege limit that privilege to persons actually licensed.⁵⁴

In short, the federal law with regard to the application of the psychotherapist-patient privilege to unlicensed persons is not settled. This particular uncertainty is perhaps more significant with regard to communications involving mental health than it would be if the privilege were extended to cover general physician-patient communications. There are simply more persons who may be authorized but not licensed to provide mental counseling than treatment for physical ailments. Nevertheless, if the privilege were to be broadened into a wider physician-patient privilege, a determination would have to be made as to whether the privilege

47. *Id.*

48. *Id.*

49. *Id.* at 657–58.

50. *Id.* at 658.

51. 206 F.R.D. 306, 310 (S.D. Ala. 2002); *see also supra* note 30 and accompanying text.

52. *Jane Student 1*, 206 F.R.D. at 310.

53. *Id.* at 309.

54. *Id.* at 310; *see also* *Carman v. McDonnell Douglas Corp.*, 114 F.3d 790 (8th Cir. 1997) (holding there is no privilege for communications to company ombudsman despite presumed confidentiality of such communications).

would cover such individuals as physicians' assistants and company nurses not operating under the direct supervision of a physician. Such persons may be "licensed" but they are not licensed physicians.⁵⁵

D. The Communication Must Be in Confidence

Federal cases dealing with the psychotherapist privilege, both before and after *Jaffee*, have insisted on circumstances supporting a finding that the communications were in confidence. For example, in *In re Doe*,⁵⁶ the court did not reach a definitive conclusion as to whether a psychotherapist-patient privilege existed. Instead, it held that, even if such a privilege existed, it would not apply where there were no communications of "the intensely personal nature that the psychotherapist-patient privilege is designed to protect from public scrutiny."⁵⁷ In *Doe*, the communications were from seventy patients a day who were seeking the dispensing of a controlled substance.⁵⁸

Similarly, *In re Zuniga*⁵⁹ involved records from a psychotherapist accused of defrauding Blue Cross-Blue Shield.⁶⁰ The court recognized the existence of the psychotherapist privilege but refused to protect the patient's identity or the fact and time of his treatment, stating:

In weighing these competing interests, the Court is constrained to conclude that, under the facts of this case, the balance tips in favor of disclosure. The essential element of the psychotherapist-patient privilege is its assurance to the patient that his innermost thoughts may be revealed without fear of disclosure. Mere disclosure of the patient's identity does not negate this element. Thus, the Court concludes that, as a general rule, the identity of a patient or the fact and time of his treatment does not fall within the scope of the psychotherapist-patient privilege.⁶¹

55. Again, the issue is clearer where the unlicensed person is an agent of the psychotherapist or, in the case of a broadened privilege, of the physician. See *supra* note 41 and accompanying text.

56. 711 F.2d 1187, 1193-94 (2d Cir. 1983).

57. *Id.*

58. *Id.* at 1190.

59. 714 F.2d 632 (6th Cir. 1983).

60. *Id.* at 634.

61. *Id.* at 640; see also *In re Grand Jury Subpoenas Duces Tecum Dated*

Post-*Jaffee* cases also hold that the identity of a patient or the date of his or her treatment is not within the privilege.⁶² Other issues that have arisen after *Jaffee* in connection with the confidentiality of communications involve instances in which a session with a psychotherapist was mandatory and whether a report of the session was to be made to someone other than the patient. Most of the cases dealing with the issue have involved situations where, like *Jaffee*, a police officer has been ordered to undergo some kind of psychological evaluation.⁶³

Courts have usually held that the privilege still applies despite the mandatory nature of the psychological evaluation.⁶⁴ Courts have refused to apply the privilege where the police officer knew that the results of the session would be reported to his or her superiors.⁶⁵

Jan. 30, 1986, 638 F. Supp. 794, 797-99 (D. Me. 1986) (citing *Zuniga*, the court held that the psychotherapist privilege does not preclude disclosure of the identity of a patient or the fact and time of the treatment).

62. See *Santelli v. Electro-Motive*, 188 F.R.D. 306, 310 (N.D. Ill. 1999); *Vanderbilt v. Town of Chilmark*, 174 F.R.D. 225, 230 (D. Mass. 1997); *Hucko v. City of Oak Forest*, 185 F.R.D. 526, 531 (N.D. Ill. 1999); *Booker v. City of Boston*, Nos. 97-CV-12534-MEL, 97-CV-12675-MEL, 1999 WL 734644 (D. Mass. Sept. 10, 1999).

63. See *supra* note 65 and accompanying text.

64. See *Speaker v. County of San Bernardino*, 82 F. Supp. 2d 1105, 1116-17 (C.D. Cal. 2000) (holding that the fact that the session is mandatory does not destroy the privilege where the patient is told by his employer that the session would be confidential); *Caver v. City of Trenton*, 192 F.R.D. 154, 162 (D.N.J. 2000) (holding that the privilege applied where no confidential information was disclosed by psychologist to police chief, but rather only a "yes" or "no" as to whether the officer was fit to return to duty).

65. See *Barrett v. Vojtas*, 182 F.R.D. 177 (W.D. Pa. 1998). In *Barrett*, the court held that the privilege did not apply where a police officer was ordered to seek treatment and "more importantly" knew that the psychiatrist would report back to the police department with regard to the examination. The officer knew that a status report and recommendations would be made. The fact that he thought communications themselves would be confidential did not make the privilege applicable. *Id.*; see also *Kamper v. Gray*, 182 F.R.D. 597 (E.D. Mo. 1998) (refusing to apply the privilege when a police officer knew that the results of an evaluation would be reported to his superiors. In contrast, with regard to another police officer, a voluntary professional counseling session was held to be protected); *Scott v. Edinburg*, 101 F. Supp. 2d 1017, 1020 (N.D. Ill. 2000) (holding no privilege existed where the police officer knew that psychological testing results would be reviewed by the police chief); *Siegel v. Abbottstown Borough*, No. Civ.1:03-CV-0549, 2004 WL 230892, at *4 (M.D. Pa. Jan. 30, 2004) (holding no privilege existed where patient knew report would be transmitted to others).

E. The Privilege is Absolute

The Court in *Jaffee* emphasized the absolute nature of the psychotherapist privilege.⁶⁶ The privilege incorporated in Proposed Rule 504 was likewise absolute.⁶⁷

Nevertheless, a few district court cases after *Jaffee* have held that the privilege must be qualified where the defendant seeks information otherwise within the privilege to assist in making out a defense in a criminal case.⁶⁸ In *United States v. Alperin*,⁶⁹ the defendant sought the psychiatric records of the assault victim in support of the defendant's self-defense claim. The court applied the federal privilege announced in *Jaffee*,⁷⁰ but stated that the need for confidentiality had to be balanced against the defendant's Sixth Amendment rights to a fair trial and to confront witnesses.⁷¹ Although the court applied the privilege in a case governed by federal law, it looked to California cases that had balanced the privilege against the rights of an accused in a criminal case.⁷² The court ordered an *in camera* review of the psychiatric records to determine the value of the evidence to the defendant.⁷³

In *United States v. Hansen*,⁷⁴ the court dealt with a request for psychiatric records of a now-deceased victim. The court held that the psychiatrist could assert the privilege on behalf of the deceased patient, but it nevertheless ordered production of the records, stating:

The holder of the privilege has little private interest in preventing disclosure, because he is dead. The public does

66. *Jaffee*, 518 U.S. at 17. Some earlier federal court precedent had described a qualified psychotherapist-patient privilege. See, e.g., *In re Doe*, 964 F.2d 1325, 1328 (2d Cir. 1992).

67. FED. R. EVID. 504(c) (Version Promulgated by the U.S. Supreme Court Nov. 20, 1972), 56 F.R.D. 183, 240 (1973).

68. See, e.g., *United States v. Alperin*, 128 F. Supp. 2d 1251 (N.D. Cal. 2001); *United States v. Hansen*, 955 F. Supp. 1225 (D. Mont. 1997); *United States v. Haworth*, 168 F.R.D. 660 (D. N.M. 1996).

69. 128 F. Supp. 2d 1251 (N.D. Cal. 2001).

70. *Id.* at 1252.

71. *Id.* at 1253.

72. *Id.* at 1253-54.

73. *Id.* at 1255; see also *United States v. Mazzola*, 217 F.R.D. 84, 88 (D. Mass. 2003) (holding that the federal psychotherapist-patient privilege did not prevent disclosure to defense of therapist records of important government witness in a criminal prosecution).

74. 955 F. Supp. 1225 (D. Mont. 1997).

have an interest in preventing disclosure, since persons in need of therapy may be less likely to seek help if they fear their most personal thoughts will be revealed, even after their death. . . . However, I find that the defendant's need for the privileged material outweighs this interest.⁷⁵

In *United States v. Haworth*,⁷⁶ the court recognized the defendant's Sixth Amendment rights to information relevant to his defense, but nevertheless held that there was no right to examine records that were privileged under the psychotherapist-patient privilege.⁷⁷ The defendant would be permitted to cross-examine the patient regarding his treatment, however.⁷⁸

On the other side of the ledger, the court in *United States v. Doyle*⁷⁹ held that defendant's Sixth Amendment rights did not trump the confidentiality of a victim's statements to a psychotherapist in the context of a sentencing hearing.⁸⁰ Whatever impact Sixth Amendment considerations have on the psychotherapist-patient privilege would also apply to a broader physician-patient privilege.

F. The Privilege is Waived When the Patient Relies Upon the Condition as an Element of a Claim or Defense in Any Legal Action

There are many federal cases, almost all from the district courts, dealing with whether a party has waived the psychotherapist privilege by asserting a claim of emotional distress or similar damage.⁸¹ A clear majority of the cases favor the rule that a party waives the privilege by making a claim for emotional damages.⁸² The cases following this majority rule are divided into those that find that a mere claim in a pleading is sufficient for there to be a waiver (referred to below as the "broad" rule)⁸³ and those that require some indication that the plaintiff will offer some form of expert testimony

75. *Id.* at 1226 (citations omitted). The court did not elaborate as to whether it would have reached a different result had the patient still been alive.

76. 168 F.R.D. 660 (D.N.M. 1996).

77. *Id.* at 661-62.

78. *Id.* at 662.

79. 1 F. Supp. 2d 1187 (D. Or. 1998).

80. *Id.* at 1190.

81. See *infra* Parts I.F.1-3.

82. See *id.*

83. See *infra* Part I.F.1.

on the issue (referred to below as the “in-between” rule).⁸⁴ A minority of cases hold that a plaintiff does not waive the privilege unless he or she introduces the testimony of the psychotherapist to whom the confidential statements were made or testifies about those statements (referred to below as the “narrow” rule).⁸⁵

1. The Broad Rule

Several courts have held that the mere pleading of emotional distress is sufficient to waive the privilege.⁸⁶ The court’s opinion in *Sarko v. Penn-Del Directory Co.*,⁸⁷ is illustrative of the reasoning of courts taking this position. In *Sarko*, the court gave three basic reasons for finding waiver. First, it relied on pre-*Jaffee* decisions that had found waiver.⁸⁸ Secondly, it noted that the *Jaffee* decision had analogized the policy considerations supporting the psychotherapist privilege to those supporting the attorney-client privilege and that the latter privilege is waived when the advice of counsel is in issue.⁸⁹ Lastly, quoting from *Premack v. J.C.J.*

84. See *infra* Part I.F.2.

85. See *infra* Part I.F.3.

86. E.g., *Lanning v. S.E. Pa. Transp. Auth.*, Nos. CIV. A. 97-593, CIV. A. 97-1161, 1997 WL 597,905, at *2-3 (E.D. Pa. Sept. 17, 1997); *EEOC v. Danka Indus., Inc.*, 990 F. Supp. 1138, 1141-42 (E.D. Mo. 1997); *Sidor v. Reno*, No. 95 CIV. 9588(KMW), 1998 WL 164,823 (S.D.N.Y. Apr. 7, 1998). In *Sidor*, the plaintiff not only sought damages for emotional distress but challenged the decision of her employer to terminate her on the grounds that she was dangerous to herself and to others. *Id.* at *1; see also *Kirchner v. Mitsui & Co. (U.S.A.)*, 184 F.R.D. 124, 128-29 (M.D. Tenn. 1998) (ruling plaintiff waived the privilege by raising the issue of her emotional condition under both case precedent and Tennessee’s psychiatrist-patient privilege statute); *Doe v. City of Chula Vista*, 196 F.R.D. 562, 563, 568 (S.D. Cal. 1999) (reversing magistrate judge’s opinion adopting the narrow view of privilege and adopting the broad view); *Sanchez v. U.S. Airways, Inc.*, 202 F.R.D. 131, 136 (E.D. Pa. 2001) (finding that plaintiff waived the privilege by putting his emotional state at issue because of the strong need to allow defendant to establish a defense); *Dixon v. City of Lawton, Okla.*, 898 F.2d 1443, 1451 (10th Cir. 1990) (holding in a pre-*Jaffee* case that, even if plaintiff had not raised the mental condition, the privilege would have been waived as pertaining to the defense).

87. 170 F.R.D. 127 (E.D. Pa. 1997).

88. *Id.* at 130. The court cites *Topol v. Trs. of the Univ. of Pa.*, 160 F.R.D. 476, 477 (E.D. Pa. 1995); *Price v. County of San Diego*, 165 F.R.D. 614, 622 (S.D. Cal. 1996); *Sarko*, 170 F.R.D. at 130.

89. *Sarko*, 170 F.R.D. at 130.

Ogar, Inc.,⁹⁰ the court stated: "we agree that allowing a plaintiff 'to hide . . . behind a claim of privilege when that condition is placed directly at issue in a case would simply be contrary to the most basic sense of fairness and justice.'"⁹¹

2. The In-Between Rule

Several courts have held that a party waives the privilege, not simply by filing a pleading claiming emotional distress, but by designating an expert to testify on that issue even though the expert was not the psychotherapist involved in the confidential communications.

Illustrative of this approach is a case from the Northern District of Illinois, *Santelli v. Electro-Motive*.⁹² In *Santelli*, the court rejected both a bright line broad and a bright line narrow test.⁹³ It specifically rejected the holding in *Vanderbilt v. Town of Chilmark*,⁹⁴ the leading case setting forth the narrow approach, that the privilege is waived only by introducing evidence of the communication or by calling the particular psychotherapist as a witness.⁹⁵ The court expressed concern that this narrow view would permit the plaintiff to call a non-treating psychotherapist and prevent cross-examination based upon what she had told her treating psychotherapist.⁹⁶ The court said, however, that the mere assertion of a claim for emotional distress was not sufficient.⁹⁷ In *Santelli*, the plaintiff had expressly limited her claim to negative emotions she suffered from the alleged sex discrimination and retaliation and indicated she would forego introducing evidence about emotional distress that necessitated care or treatment by a physician.⁹⁸ Describing its view of the application of the waiver rule in this instance, the court stated, "[w]hile we believe that a party waives her psychotherapist-patient privilege by electing to inject into a case either the fact of her treatment or any

90. 148 F.R.D. 140, 144-45 (E.D. Pa. 1993).

91. *Sarko*, 170 F.R.D. at 130 (alteration in original).

92. 188 F.R.D. 306 (N.D. Ill. 1999).

93. *Id.* at 308-09.

94. 174 F.R.D. 225, 229 (D. Mass. 1997). For a discussion of the *Vanderbilt* case, see *infra* notes 107-115 and accompanying text.

95. *Santelli*, 188 F.R.D. at 308-09.

96. *Id.* at 308.

97. *Id.* at 309.

98. *Id.*

symptoms or conditions that she may have experienced, Santelli is doing neither.”⁹⁹

Another significant case taking this “in-between” view is *Speaker v. County of San Bernardino*.¹⁰⁰ *Speaker* involved a claim against a law enforcement officer who had shot and killed the plaintiff’s family member.¹⁰¹ The court held that the defendant police officer waived his privilege as to the question of perception distortion “by testifying that his perception of the incident was distorted, and submitting the report of an expert that the distortion resulted from the trauma of the incident.”¹⁰² The court found no waiver with regard to other aspects of the defendant’s consultation with a psychotherapist, however.¹⁰³ The court discussed both the broad and narrow views of the privilege but stated that it would have reached the same result under either rule.¹⁰⁴ The court held that the patient, whether appearing as the plaintiff or defendant, must actually make his or her condition an issue in order to waive the privilege.¹⁰⁵

Several other district court cases take a similar approach to the issue.¹⁰⁶

99. *Id.*

100. 82 F. Supp. 2d 1105, 1118–20 (C.D. Cal. 2000).

101. *Id.* at 1107.

102. *Id.* at 1118.

103. *Id.* at 1118–20.

104. *Id.*

105. *Id.* at 1120.

106. See *Allen v. Cook County Sheriff’s Dep’t*, No. 97C3625, 1999 WL 168466, at *2 (N.D. Ill. Mar. 17, 1999) (finding that merely seeking damages for emotional distress does not waive the privilege; the plaintiff would waive privilege if she put her mental condition at issue by disclosing that she intended to call her psychotherapists or another expert to establish her claim); *Hucko v. City of Oak Forest*, 185 F.R.D. 526 (N.D. Ill. 1999) (finding no waiver where the plaintiff merely asserted a claim for emotional distress; distinguishes cases where the plaintiff has offered or indicated any intent to offer prior consultation with psychiatrist in order to support claims). The court in *Hucko* found waiver based upon the plaintiff’s assertion that the statute of limitations should be tolled because he was preoccupied with treatment and medications. *Id.* at 531–32; see also *Adams v. Ardcor*, 196 F.R.D. 339, 344 (E.D. Wis. 2000) (following *Santelli* and *Hucko* in finding that the mere inclusion of a request for damages based on emotional distress does not waive the privilege, but naming a psychologist as an expert witness waived the privilege as to other consultations with psychotherapists); *Noggle v. Marshall*, 706 F.2d 1408, 1415 (6th Cir. 1983) (holding in a pre-*Jaffee* case that the “privilege was waived not merely by [the defendant’s] plea of insanity but by

3. The Narrow Rule

The leading case setting forth the narrow view of waiver is *Vanderbilt v. Town of Chilmark*.¹⁰⁷ In *Vanderbilt*, the plaintiff sought damages for gender discrimination, claiming emotional distress.¹⁰⁸ The court disagreed with the broad view of waiver as set forth in the *Sarko* case.¹⁰⁹ Unlike the court in *Sarko*, the court in *Vanderbilt* rejected any argument based on pre-*Jaffee* decisions, noting that the Court in *Jaffee* had made a point of rejecting any balancing in connection with the psychotherapist-patient privilege.¹¹⁰ The court equated a finding of waiver of the privilege because the evidence is relevant to a claim made by the patient with the sort of balancing, or qualified privilege, rejected in *Jaffee*.¹¹¹ Secondly, in *Sarko*, the court had analogized the situation to waivers under the attorney-client privilege where there is waiver if the client relies on the advice of counsel.¹¹² The court in *Vanderbilt* argued that the case before it was not based on the advice of the psychotherapist but was rather more like a suit for attorney's fees where, the court said, there is no waiver.¹¹³ Third, the court in *Sarko* had based its holding in part on the fairness of permitting the opposing party to introduce the communications with the psychotherapist where the patient relies on his emotional condition as an element of his claim or as a basis for damages.¹¹⁴ The court in *Vanderbilt* rejected the *Sarko* analysis in this regard, finding that waiver would be justified only if the plaintiff were to introduce the substance of the conversations with the psychotherapist.¹¹⁵

the defense putting medical experts on the stand who testified that he was insane.”).

107. 174 F.R.D. 225, 227–30 (D. Mass. 1997).

108. *Id.* at 226.

109. *Id.* at 228–30. For a discussion of *Sarko*, see *supra* notes 87–91 and accompanying text.

110. *Id.* at 228–29. For a discussion of *Jaffee*'s holding, see *supra* notes 6–10 and accompanying text.

111. *Id.* at 229.

112. *Id.*

113. *Id.* The court's statement with regard to the nonwaiver of the attorney-client privilege in a case involving fees is not in accord with the general law governing that privilege. See RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 133(a) (1996).

114. *Vanderbilt*, 174 F.R.D. at 229–30.

115. *Id.* at 230. Other cases taking the narrow view include: *Fitzgerald v.*

One cannot predict where the federal courts will go with regard to the waiver of the privilege in cases where the patient's mental condition is in issue. The weight of authority would favor either the broad or the in-between rule. In any event, the existence of some significant limitation on the privilege in cases in which the patient's condition is in issue would certainly operate as a significant check on the application of any broader physician-patient privilege.

G. *The Crime-Fraud Exception*

Proposed Federal Rule 504 did not contain a crime-fraud exception.¹¹⁶ Although the matter has apparently arisen infrequently in the federal courts, however, at least one Court of Appeals has found the existence of such an exception.¹¹⁷

In *In re Grand Jury Proceedings (Gregory P. Violette)*,¹¹⁸ the defendant was charged with presenting trumped up disabilities for the purpose of obtaining credit disability insurance payments.¹¹⁹ The government sought information through grand jury subpoenas from the defendant's psychiatrists; the defendant claimed privilege.¹²⁰ The lower court had found the *Jaffee* privilege to be inapplicable because the defendant did not have a *bona fide* therapeutic purpose in consulting the psychiatrists.¹²¹ While not necessarily disagreeing with that analysis, the Court of Appeals preferred to deal with the situation as one in which the privilege as articulated in *Jaffee* applied, but where an exception for statements made for the purpose of facilitating a criminal act came into play.¹²² The court used precedent involving the attorney-client privilege to reach its result,¹²³

Cassil, 216 F.R.D. 632, 638–40 (N.D. Cal. 2003); *Booker v. City of Boston*, Nos. 97-CV-12534-MEL, 97-CV-12675-MEL, 1999 WL 734644, at * 1 (D. Mass. Sept. 10, 1999) (privilege not waived unless the plaintiff makes positive use of the privileged material); see also Ellen E. McDonnell, Note, *Certainty Thwarted: Broad Waiver Versus Narrow Waiver of the Psychotherapist-Patient Privilege after Jaffee v. Redmond*, 52 HASTINGS L.J. 1369 (2001).

116. FED. R. EVID. 504 (Version Promulgated by U.S. Supreme Court Nov. 20, 1972), 56 F.R.D. 183, 240–41 (1973).

117. UNIF. R. EVID. 504(d)(4) provides for a crime-fraud exception.

118. 183 F.3d 71 (1st Cir. 1999).

119. *Id.* at 72.

120. *Id.* at 73.

121. *Id.* at 73–74.

122. *Id.* at 74–78.

123. *Id.* at 75.

especially *United States v. Jacobs*,¹²⁴ a Second Circuit case. The court described the exception to the attorney-client privilege as applying in cases such as *Jacobs* when “the client was engaged in (or was planning) criminal or fraudulent activity when the attorney-client communications took place . . . [and] the communications were intended by the client to facilitate or conceal the criminal activity.”¹²⁵ The court applied the same policy to the psychotherapist-patient privilege, stating that the mental health benefits of protecting such communications “pale in comparison to ‘the normally predominant principal of utilizing all rational means for ascertaining truth.’”¹²⁶ The court stated that the exception applies “when communications are intended directly to advance a particular criminal or fraudulent endeavor”¹²⁷ The court found that the evidence in *Violette*, consisting of the government agent’s affidavit establishing that the defendant was engaged in illegal and fraudulent conduct and that he obtained assistance from the psychiatrists, was sufficient for the exception to be invoked.¹²⁸ The court noted that the exception applied even though the doctors may have been “unwitting pawns” in the defendant’s scheme.¹²⁹

The crime-fraud privilege is a significant limitation on the attorney-client privilege.¹³⁰ Although the matter predictably has come up far less frequently in connection with the psychotherapist-patient privilege, the recognition of the exception in cases such as *Violette* serves notice that it is probably an important limitation on that privilege as well. It would be equally significant if the privilege were expanded to cover communications of physical ailments as well.

124. 117 F.3d 82, 87–89 (2d Cir. 1997).

125. *Violette*, 183 F.3d at 75.

126. *Id.* at 77 (citation omitted).

127. *Id.*

128. *Id.* at 78.

129. *Id.* at 78–79.

130. For an extensive discussion of the crime-fraud exception in various texts, see EDWARD J. IMWINKELRIED, *THE NEW WIGMORE: A TREATISE ON EVIDENCE: EVIDENTIARY PRIVILEGES* § 6.13.2(d) (2002); JOHN W. STRONG ET AL., 1 *MCCORMICK ON EVIDENCE* §95 (5th ed. 1999).

H. The Privilege May Be Subject to an Exception Where the Patient has Expressed an Intention to Engage in Conduct Likely to Result in Imminent Death or Serious Bodily Injury to the Patient or Another Individual

Although less likely to arise in instances where the communication involves physical as opposed to mental diagnoses, it is nevertheless important to note the possibility of an exception to the psychotherapist-patient privilege where the patient has expressed an intent to engage in conduct likely to result in imminent death or serious bodily injury to the patient or another individual.¹³¹ For example, the issue could arise in psychotherapist-patient cases where the patient has conveyed a threat of suicide to his or her psychotherapist. The same issue could also arise with regard to a terminally ill patient's suicidal threats conveyed to her internist or oncologist.

The primary support for this exception to the psychotherapist-patient privilege is contained in a footnote to the *Jaffee* case, where the Court wrote:

Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.¹³²

Although Proposed Federal Rule 504 contained no such exception,¹³³ at least one circuit has recognized its existence. In

131. *Jaffee*, 518 U.S. at 18, n.19.

132. *Id.* See generally, George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The Tarasoff Duty and the Jaffee Footnote*, 74 WASH. L. REV. 33 (1999).

133. FED. R. EVID. 504 (Revised Proposed Draft Mar. 1971), 51 F.R.D. 315, 366-67 (1971). Uniform Rule of Evidence 503(d)(5) does contain such an exception: "(d) There is no privilege under this rule for a communication: . . . (5) that the patient intends to kill or seriously injure the patient or another individual." A few states have codified such an exception to the privilege. See CAL. EVID. CODE § 1024, p. 192 (1995) ("There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."); see also FLA. STAT. ANN. § 456-59 (West 2001).

United States v. Glass,¹³⁴ the defendant had expressed a threat to his psychotherapist to kill President Clinton and his wife.¹³⁵ The court, noting the *Jaffee* footnote, stated that it would recognize the existence of an exception to the privilege that would apply to a threat that was serious when uttered and where disclosure was the only means of averting harm.¹³⁶ The case was remanded for a review of the seriousness of the threat.¹³⁷

Two circuits, the Ninth and the Sixth, have rejected the existence of a "dangerous patient" exception when it was raised in a criminal trial after the threat had ceased to exist.¹³⁸ In *United States v. Hayes*,¹³⁹ the court dealt with threats to federal officers and a claim of privilege based upon the psychotherapist-patient privilege.¹⁴⁰ The court distinguished between the ethical duty of a psychotherapist to disclose threats to prevent harm to others and a required disclosure at a court hearing after the threat had passed.¹⁴¹ The court found the footnote in *Jaffee* to relate to the former situation, but not the latter.¹⁴² The strong dissent in *Hayes* states that once the psychotherapist has informed the patient of the need to disclose threats for the protection of others, the privilege no longer attaches.¹⁴³

The Ninth Circuit, sitting *en banc*, reached the same result in *United States v. Chase*.¹⁴⁴ In *Chase*, the psychiatrist had informed the FBI of threats made by the defendant, her patient, against FBI agents.¹⁴⁵ The court noted that the psychiatrist was acting in accordance with state law that permitted her to deviate from the confidentiality required of psychotherapists for the protection of third parties.¹⁴⁶ Justifying disclosure of confidences is not the same as

134. 133 F.3d 1356 (10th Cir. 1998).

135. *Id.* at 1357.

136. *Id.* at 1360.

137. *Id.*

138. *See, e.g., United States v. Hayes*, 227 F.3d 578 (6th Cir. 2000); *United States v. Chase*, 340 F.3d 978 (9th Cir. 2003).

139. 227 F.3d 578 (6th Cir. 2000).

140. *Id.* at 580–81.

141. *Id.* at 583–84.

142. *Id.* at 585.

143. *Id.* at 588 (Bogg, J., dissenting).

144. 340 F.3d 978.

145. *Id.* at 980.

146. *Id.* at 984–85.

requiring the psychotherapist to testify in court once the danger has passed, however.¹⁴⁷ Based primarily on this reasoning,¹⁴⁸ the court, as did the Sixth Circuit in *Hayes*,¹⁴⁹ rejected a “dangerous patient” exception to the psychotherapist-patient privilege in a criminal case occurring after the threat had ceased to exist.¹⁵⁰

I. Conclusion

Too short of a time has passed since the affirmation of a psychotherapist-patient privilege in *Jaffee* to expect the full parameters of the privilege to be fully entrenched. Yet, particularly with the use of Proposed Federal Rule 504 as a guideline, the dimensions of the privilege are fairly well established. Looking at the way in which the psychotherapist-patient privilege has developed may be useful in determining whether there should be a general physician-patient privilege as well as the precise parameters of that privilege.

147. *Id.*

148. The court in *Chase* articulated other reasons for rejecting the exception including: 1) the absence of such an exception in most state privilege laws, *id.* at 985–86; 2) the differing standards in each state for breach of confidentiality would make the application of an exception to the federal privilege impractical, *id.* at 986–89; 3) the absence of such an exception in Proposed Federal Rule of Evidence 504, *id.* at 989–90; 4) several public policy considerations including the court’s belief that “a patient will retain significantly greater residual trust when the therapist can disclose only for protective, rather than punitive, purposes.” *Id.* at 990. Despite finding the existence of the privilege and the absence of the exception, the court refused to reverse, finding the error to be harmless. *Id.* at 992–93.

149. The concurring opinion in *Chase*, signed by three judges of the *en banc* court, would have adopted the exception based in large measure on the footnote in *Jaffee* cited in the text accompanying *supra* note 132. *Id.* at 996. The concurring judges also based their acceptance of the exception and rejection of the majority opinion at least in part on the argument that once disclosure is made “the patient has lost the medical benefit of being able to speak to his psychotherapist in confidence that what he says will remain secret.” *Id.* at 996–97 (Kleinfeld, J., concurring).

150. *Id.* at 992.

II. THE ARGUMENTS FOR AND AGAINST A GENERAL PHYSICIAN-PATIENT PRIVILEGE

A. *The Trouble With Jaffee*

The Court in *Jaffee*, by dictum, firmly rejected a general physician-patient privilege, distinguishing statements made to psychotherapists from those made to physicians for physical ailments where treatment can often proceed on the basis of physical examination, objective information and results of diagnostic tests.¹⁵¹

The Court's rejection of a general physician-patient privilege was consistent with holdings throughout the federal system prior to *Jaffee*.¹⁵² Not surprisingly, no federal court has recognized such a privilege since *Jaffee*.¹⁵³

Although the Court's decision rejecting a general physician-patient privilege is arguably sound, its rationale is suspect in at least two respects. First, the Court's distinction between statements made for purposes of diagnosis or treatment of physical, as opposed to mental or emotional, problems does not withstand close or even not so close scrutiny.¹⁵⁴ The medical literature is replete with statements

151. *Jaffee*, 518 U.S. at 10. See *supra* note 10 and accompanying text.

152. Examples of cases rejecting a general physician-patient privilege are *Hancock v. Dodson*, 958 F.2d 1367, 1373 (6th Cir. 1992); *United States v. Moore*, 970 F.2d 48, 50 (5th Cir. 1992); and *United States v. Bercier*, 848 F.2d 917, 920 (8th Cir. 1988).

153. In light of the clear precedent rejecting the existence of the privilege, few cases spend much time on the issue. Examples of the many cases in which courts have specifically noted the absence of such a federal privilege include *N.W. Mem'l. Hosp. v. Ashcroft*, 362 F.3d 923, 926 (7th Cir. 2004); *United States v. La. Clinic*, No. CIV. A. 99-1767, 2002 WL 31819130, at *2 (E.D. La. Dec. 12, 2002); and *In re Grand Jury Subpoena*, 197 F. Supp. 2d 512, 513-14 (E.D. Va. 2002).

154. The Court in *Jaffee* was not alone in distinguishing between communications with regard to physical concerns and those involving mental problems. In *Wei v. Bodner*, the court stated:

The relationship between a psychotherapist and her patient is substantially different from that between a doctor and her patient. Patients must confide their most intimate dreams, hopes, fears, and other personal information to their therapists. Without full disclosure there is little hope that the therapy can be successful. While there are other medical situations in which confidentiality may be equally important, courts have recognized the special relationships that psychotherapists have with their patients in according these communications legal confidentiality in some situations.

concerning the need for physicians to communicate with their patients and the importance of adequate information from patients.¹⁵⁵ The Ethics Manual of the American College of Physicians states, "At the beginning of a patient-physician relationship, the physician must understand the patient's complaints, underlying feelings, goals, and expectations."¹⁵⁶

One does not have to have medical training to understand that a physician must rely on the patient's statements of past medical history, recent symptoms and subjective feelings, e.g., pain. If a police officer, as in the *Jaffee* case, saw a general physician to treat, for example, back pain, the physician, like the psychotherapist, might have good reason to inquire as to incidents that might have caused stress in her life. And the police officer might be reluctant to fully discuss such incidents unless there was an assurance of privilege in a subsequent court proceeding.

In addition to distinguishing statements with regard to physical ailments from those involving mental illness, the Court in *Jaffee*, in adopting the psychotherapist-patient privilege, relied heavily on the fact that such a privilege existed in all fifty states. The Court stated:

That it is appropriate for the federal courts to recognize a psychotherapist privilege under Rule 501 is confirmed by the fact that all 50 States and the District of Columbia have enacted into law some form of psychotherapist privilege. We have previously observed that the policy decisions of the States bear on the question whether federal courts should recognize a new privilege or amend the coverage of an existing one. Because state legislatures are fully aware of the need to protect the integrity of the factfinding functions of their courts, the existence of a consensus

127 F.R.D. 91, 97 (D. N.J. 1989) (citation omitted).

155. See Mi Young Hwang, *How to Talk with Your Doctor*, 282 J. AM. MED. ASS'N, Dec. 22/29, 1999, at 2422 (recommending that patients be prepared to be "completely honest about [their] lifestyle, including . . . diet, use of alcohol or other drugs, smoking history, sexual history, and other health care [they] receive."); Zeldi Di Blasi et al., *Influence of Context Effects on Health Outcomes: A Systematic Review*, 357 THE LANCET Mar. 10, 2001, at 757 (emphasizing the need for emotional as well as physical care in the treatment of physical ailments).

156. American College of Physicians, ETHICS MANUAL, (4th ed. 1998), www.acponline.org/ethics/ethicman.htm (last visited Oct. 19, 2004).

among the States indicates that "reason and experience" support recognition of the privilege. In addition, given the importance of the patient's understanding that her communications with her therapist will not be publicly disclosed, any State's promise of confidentiality would have little value if the patient were aware that the privilege would not be honored in a federal court. Denial of the federal privilege therefore would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.¹⁵⁷

In reaching its decision in *Jaffee*, the Court set forth a privilege that applied not only to licensed psychologists and psychiatrists but to licensed social workers as well.¹⁵⁸ The Court noted that all but five states applied their psychotherapist privilege to such professionals.¹⁵⁹

That significant majority of states could apply equally in the case of a general physician-patient privilege. Forty-one states, the District of Columbia, and several United States territories have such a privilege.¹⁶⁰ Furthermore, all but North Carolina and Virginia provide for an absolute privilege.¹⁶¹ Accordingly, the percentage of states' laws protecting such communications is extremely close to those involving communications to licensed social workers.

Thus, the fact that the Court's dicta in *Jaffee* rejected a general physician-patient privilege is, at least, suspect. Whether such suspicion justifies the adoption of such a privilege is, of course, another question.

B. Legal Scholarship

1. Scholarship opposed to a general physician-patient privilege

Many of the great evidence scholars of the past expressed an opinion with regard to a general physician-patient privilege. Up to the time of the Proposed Federal Rules of Evidence, there was virtually unanimous scholarly agreement that the protection of communications between physicians and their patients was not sufficiently important either to the freedom of communication

157. *Jaffee*, 518 U.S. at 12-13 (citation and footnotes omitted).

between patient and physician, or to society as a whole, to justify the potential loss of valuable information to the judicial process.¹⁶²

In large measure, a scholar's receptivity to the privilege depended upon his or her view of the theory of the privilege: utilitarian, protective of the right of privacy, or otherwise. John Henry Wigmore, the nation's most revered evidence scholar, took a purely utilitarian view of privileges generally. He set forth four widely cited "canons," which he said every privilege must satisfy:

- 1) The communications must originate in a *confidence* that they will not be disclosed.
- 2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
- 3) The *relation* must be one which in the opinion of the

158. *Id.* at 15.

159. *Id.* at 16–17, n.17.

160. ALASKA R. EVID. 504; ARIZ. REV. STAT. ANN. § 12-2235 (West 2003); ARK. R. EVID. 503; CAL. EVID. CODE § 994 (West 2004); COLO. REV. STAT. § 13-90-107(d) (2001); CONN. GEN. STAT. ANN. § 52-1460 (West Supp. 2004); DEL. R. EVID. 503; D.C. CODE ANN. § 14-307 (2001); GA. CODE ANN. § 24-9-40 (2003); GUAM. R. EVID. § 503(f); HAW. R. EVID. 504; IDAHO R. EVID. 503; 735 ILL. COMP. STAT. ANN. 5/8-802 (West 2003); IND. CODE ANN. § 34-46-3-1 (Michie 1998); IOWA CODE ANN. § 622.10(3)(c) (West 1999); KAN. STAT. ANN. § 60-427 (1994); LA. CODE EVID. ANN. art. 510 (West Supp. 2004); ME. R. EVID. 503; MICH. COMP. LAWS. SERV. § 600.2157 (LEXIS 2004); MINN. STAT. ANN. § 595.02(d) (West 2000); MISS. R. EVID. 503; MO. ANN. STAT. § 491.060(5) (West 1996); MONT. CODE ANN. § 26-1-805 (West 2003); NEB. REV. STAT. ANN. § 27-504 (Michie 1995); NEV. REV. STAT. ANN. § 49.215-49.245 (LEXIS 2002 & Supp. 2003); N.H. REV. STAT. ANN. § 329:26 (2003); N.J. STAT. ANN. § 2A:84A-22.2 (West 1994); N.M. R. EVID. 11-504; N.Y. C.P.L.R. 4504 (McKinney 1992); N.C. GEN. STAT. § 8-53 (2003); N.D. R. EVID. 503; OHIO REV. CODE ANN. § 2317.02(B)(1) (Anderson 2001); OKLA. STAT. ANN. tit. 12, § 2503 (West 1993); OR. REV. STAT. § 40.235 (2003); 42 PA. CONS. STAT. ANN. § 5929 (West 2000); P.R. R. EVID. 26; S.D. CODIFIED LAWS § 19-13-7 (Michie 1995); TEX. R. EVID. 509; UTAH R. EVID. 506; VT. R. EVID. 503; VA. CODE ANN. § 8.01-399 (LEXIS 2000); 5 V.I. CODE ANN. § 855 (1997); WASH. REV. CODE ANN. § 5.60.060(a)(4) (West 1995); WIS. STAT. ANN. § 905.04 (West 2000); WYO. STAT. ANN. § 1-12-101(a)(i) (LEXIS 2003).

161. *See* N.C. GEN. STAT. § 8-53 (2003); VA. CODE ANN. § 8.01-399 (LEXIS 2000). New Hampshire interpreted its statute to grant a qualified privilege. *See* *State v. Elwell*, 567 A.2d 1002, 1006 (N.H. 1989).

162. CLINTON DEWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT 32–33 (1958).

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.¹⁶³

Wigmore believed that the physician-patient privilege only met the third of these canons.¹⁶⁴ He argued that in only a few instances—venereal disease and criminal abortion—did the patient attempt to reserve any secrecy.¹⁶⁵ Most of a patient's ailments are immediately disclosed and discussed.¹⁶⁶ Although Wigmore offered no empirical data to support his assumptions, he found none to be necessary, noting that "[t]hese facts are well enough known."¹⁶⁷ With regard to the second canon, he stated that "[e]ven where the disclosure to the physician is actually confidential, it would nonetheless be made though no privilege existed."¹⁶⁸ Although conceding that the relationship between physician and patient ought to be fostered as provided in the third canon, Wigmore emphatically denied that the injury to that relationship is greater than the injury to justice by prohibiting disclosure, stating:

The injury is decidedly in the contrary direction. Indeed, the facts of litigation today are such that the answer can hardly be seriously doubted.

The injury to justice by the repression of the facts of corporal injury and disease is much greater than any injury which might be done by disclosure. And furthermore, the few topics—such as venereal disease and abortion—upon which secrecy might be seriously desired by the patient come into litigation ordinarily in such issues (as when they constitute cause for a bill of divorce or a charge of crime) that for these very facts common sense and common justice

163. JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2285, at 527 (John T. McNaughton rev., photo. reprint 1981) (1961).

164. *Id.* § 2380a, at 829–30.

165. *Id.* at 829.

166. *Id.*

167. *Id.*

168. *Id.*

demand that the desire for secrecy shall not be listened to.¹⁶⁹

Wigmore dismissed the argument that to reject a physician-patient privilege, while recognizing an attorney-client privilege, was to favor the legal profession over the medical profession.¹⁷⁰ Although only grudgingly supportive of an attorney-client privilege, he noted that “the absence of the privilege would convert the attorney habitually and inevitably into a mere informer for the benefit of the opponent, while the physician, being called upon only rarely to make disclosures, is not consciously affected in his relation with the patient.”¹⁷¹

Wigmore further argued that “[n]inety-nine per cent of the litigation in which the privilege is invoked consists of three classes of cases—actions on policies of life insurance where the deceased’s misrepresentations of his health are involved, actions for [personal] injur[y] . . . and testamentary actions where the testator’s mental capacity is disputed.”¹⁷² In these classes of cases, Wigmore argued that the need for medical testimony is great and could find no reason for the physician to have to conceal the facts in those situations.¹⁷³ He concluded his diatribe against the privilege by suggesting that “[t]he real support for the privilege seems to be mainly the weight of professional medical opinion pressing upon the legislature.”¹⁷⁴

Another evidence luminary of the past, Edmund M. Morgan, expressed similar sentiments.¹⁷⁵ Morgan also argued against a physician-patient privilege on utilitarian grounds, stating:

Ordinarily a patient does not object to a dignified disclosure of his physical condition on a proper occasion, unless he is suffering from a disease ordinarily considered loathsome or disgraceful. Physicians are usually required to report such a disease to public authority and thus to make its existence a matter of public record. Certainly the typical citizen would

169. *Id.* at 830.

170. *Id.*

171. *Id.* at 831.

172. *Id.*

173. *Id.*

174. *Id.*

175. Edmund M. Morgan, *Suggested Remedy for Obstructions to Expert Testimony by Rules of Evidence*, 10 U. CHI. L. REV. 285 (1942).

much rather take a chance on having such matter brought out by the physician in a lawsuit than to endure the certainty that it would be recorded in a public office open to the eyes of subordinate clerks and employees, if not to the public. And this would be doubly true if he knew the truth that in such a lawsuit he could himself be made a witness and required to answer all pertinent questions as to his symptoms, objective and subjective, past and present. Consequently, the assumption that patients are deterred from full disclosure by reason of their desires for secrecy in future litigation has little or no basis in reason.¹⁷⁶

The classic text on the physician-patient privilege was written by Clinton DeWitt and published in 1958.¹⁷⁷ In that text, the author purports to set forth a complete exposition of the law involving the privilege, but he is no advocate for it—at least in its absolute form. He finds that the “principal reasons advanced in support of the privilege are not convincing.”¹⁷⁸ First, he rejects the notion that a person will hesitate to confide in a physician unless he has assurance that his confidences cannot later be revealed.¹⁷⁹ DeWitt notes that the basic fallacy of the theory is the unwarranted assumption that the patient knows all about the privilege and its protections.¹⁸⁰ He adds,

only a relatively small number of patients would shy at consulting a physician even though they knew that he might later be required to disclose their state of health or the nature and effect of their injuries in a court of law. . . . Ordinarily, bodily injuries and disease are attended with neither humiliation nor disgrace¹⁸¹

In exceptional cases, such as those involving venereal disease, however, the physician may be required by state law to disclose the matter into the public record.¹⁸²

DeWitt also finds that there is no evidence that the rejection of the privilege would cause an injury to the physician-patient relationship that is greater than the injury to the cause of justice.¹⁸³

176. *Id.* at 290–91.

177. DEWITT, *supra* note 162.

178. *Id.* at 34.

179. *Id.*

180. *Id.*

181. *Id.* at 35.

He fears such a privilege will suppress relevant and important evidence.¹⁸⁴ He argues that in the vast majority of reported cases in which the privilege has been invoked, the primary purpose was to use the privilege as a procedural device to win a lawsuit rather than to protect the privacy of the patient or to prevent the disclosure of matters that would humiliate or disgrace the patient.¹⁸⁵

DeWitt notes with approval the trend to require disclosure of much information that, in the past, might have been protected by the privilege, such as the requirement of listing the cause of death on death certificates and the disclosure of venereal disease under some circumstances.¹⁸⁶ He concludes by recommending either the abolition of the physician-patient privilege or, if that is not politically feasible, the substitution of a qualified privilege such as exists in North Carolina.¹⁸⁷

Other notable scholars of the twentieth century took a position similar to that expressed by Wigmore, Morgan, and DeWitt.¹⁸⁸ This seeming unanimity of animosity was undoubtedly a major factor in the elimination of a general physician-patient privilege in the set of Federal Rules first proposed in 1969.¹⁸⁹ In rejecting the general privilege, the Advisory Committee noted:

The rules contain no provision for a general physician-patient privilege. While many states have by statute created the privilege, the exceptions which have been found necessary in order to obtain information required by the public interest or to avoid fraud are so numerous as to leave little if any basis for the privilege.¹⁹⁰

182. *Id.*

183. *Id.* at 35–36.

184. *Id.* at 36.

185. *Id.* at 36–37.

186. *Id.* at 39.

187. *Id.*

188. *See, e.g.,* Zechariah Chafee, Jr., *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?*, 52 *YALE L.J.* 607 (1943); W.A. Purrington, *An Abused Privilege*, 6 *COLUM. L. REV.* 388 (1906).

189. *See supra* notes 12–23 and accompanying text.

190. *FED. R. EVID.* 504 advisory committee's note (Preliminary Proposed Draft Mar. 1969), 46 *F.R.D.* 161, 259 (1969). The Court in *Jaffee* considered the inclusion of a psychotherapist-patient privilege in the Proposed Federal Rules to be a positive factor in its recognition of the privilege under the federal

2. Scholarship in Favor of a General Physician-Patient Privilege

Ironically, despite the overwhelming scholarly authority supporting elimination of a general physician-patient privilege, the elimination of such a privilege in the proposed rules provoked many other scholars to leap to its defense. The emphasis among these writers is the protection that the privilege gives to the privacy of the individual—the patient—rather than any claim of a beneficial utilitarian effect as sought by Wigmore and the other pre-Rules writers.

One of these scholars was Charles L. Black, who pointed to the Proposed Rules as giving “major aid and comfort to that diminishment of human privacy which is one of the greater evils of our time.”¹⁹¹ He added:

If a man, consulting a heart specialist, reveals in the course of his case-history interview[] that he has had gonorrhea, then the cardiologist must divulge this in court, whenever and wherever any litigant needs the revelation. If a man under therapy for psychoneurosis reveals that his having had gonorrhea has filled him with guilt, that communication is protected. This is preposterous. It is a case of the tail ceasing to wag the dog, and continuing to wag in place after the dog has gone away. Psychotherapy is privileged, and ought to be amply privileged, exactly because it is a kind of medicine, and a human being ought to be able to consult any kind of a doctor without by that act, or by the necessities of communication consequent on that act, rendering himself vulnerable to being stripped to and below the skin in public. There is no ground whatever for singling out psychotherapy for special treatment. Any patient has to reveal his condition, verbally or otherwise, in order to be treated effectively. Moreover, for what it is worth, most

common law. *Jaffee*, 518 U.S. at 14–15. Correspondingly, the absence of a general physician-patient privilege in the proposed rules would likely be a negative factor in any future decision on the existence of such a federal common law privilege.

191. Charles L. Black, Jr., *The Marital and Physician Privileges—A Reprint of a Letter to a Congressman*, 1975 DUKE L.J. 45, 47 (1975).

competent doctors of all sorts very often concern themselves with emotional conditions.¹⁹²

Other legal writers and practicing lawyers expressed concern over the Proposed Rules at the time Congress considered them.¹⁹³ Some prominent current text writers base their support for the existence of evidentiary privileges, including a general physician-patient privilege, upon their impact on personal privacy. For example, Edward J. Imwinkelried, in his rewrite of the Wigmore treatise with regard to privileges, agrees with Wigmore insofar as he believes that the physician-patient privilege fails to meet the instrumental or utilitarian tests of privilege.¹⁹⁴ He notes “[i]t is doubtful that the patient needs any additional inducement to speak freely, especially because in many cases the thought of a lawsuit has not yet crossed the patient’s mind.”¹⁹⁵ Yet, he finds the privilege supportable on humanistic grounds:

The recognition of the privilege advances the value of autonomy privacy. Whatever the content of the person’s life plan, physical and mental health aid the person in pursuing the plan. The patient may require a psychotherapist’s assistance to preserve the patient’s cognitive and volitional ability to formulate the plan. By the same token, the patient often needs a physician’s assistance to help preserve the person’s physical capacity to carry out the person’s life plan. That assistance can entail counseling the person about even unorthodox types of medical treatment. The creation of a private enclave for the physician-patient consultations enables the patient to make more informed, independent choices among his or her medical options.¹⁹⁶

Imwinkelried raises the possibility that there is a constitutional right to informational privacy in the context of physician-patient

192. *Id.* at 51.

193. See Thomas G. Krattenmaker, *Testimonial Privileges in Federal Courts: An Alternative to the Proposed Federal Rules of Evidence*, 62 GEO. L.J. 61 (1973); see also *supra* notes 19–21.

194. EDWARD J. IMWINKELRIED, *THE NEW WIGMORE: A TREATISE ON EVIDENCE, EVIDENTIARY PRIVILEGES* § 6.2.6(A) (2002).

195. *Id.* at 495 (footnote omitted).

196. *Id.* at 498–99 (footnotes omitted).

communications, but admits that such constitutional protection is sharply disputed.¹⁹⁷ Nevertheless, he argues:

Yet, even if there is no constitutional right to informational privacy in this area, there is undeniably enhanced constitutional protection for decisional or autonomy medical privacy even outside the family realm. Lower courts have interpreted the Supreme Court precedents as conferring a measure of constitutional protection on the independence of certain decisions about medical treatment. It is unnecessary to argue that medical information is so intensely private that there is a constitutional right to informational privacy and that the Constitution compels the recognition of a privilege. So long as the patient has a constitutional interest in decisional or autonomy privacy—that is, the independence of important medical decisions—the recognition of a privilege is an appropriate means to the end of promoting that interest. The creation of a private enclave for the consultation increases the probability that as a result of the conference, the patient will make an intelligent, independent choice.¹⁹⁸

Imwinkelried balances the various considerations involving the privilege by citing with approval the North Carolina¹⁹⁹ and Virginia²⁰⁰ statutes that provide for qualified rather than absolute privileges.²⁰¹

The authors of the Wright and Graham treatise on Federal Practice and Procedure also articulate their support for a general physician-patient privilege with an argument different from Imwinkelried's, but akin to it.²⁰² These authors express concern over the vulnerability of the patient, rather than on his or her right of privacy.²⁰³ They note, "exploiting the vulnerability of those who are

197. *Id.* at 499–501.

198. *Id.* at 500–01 (footnotes omitted).

199. N.C. GEN. STAT. ANN. §8-53 (LEXIS 2003).

200. VA. CODE ANN. §§ 8.01–399 (LEXIS 2000).

201. IMWINKELRIED, *supra* note 194, at 502.

202. WRIGHT & GRAHAM, *supra* note 4, at 84–86.

203. *Id.*

disabled from illness or injury is contrary to basic human values[.]”²⁰⁴ adding:

There are several things to be noted about this version of the non-instrumental justification for the privilege. First, it does not depend upon the patient’s (self)interest in privacy nor consult his or her feelings about having the physician disclose; instead it considers the interests of the rest of us in the kind of community we have constructed for ourselves.²⁰⁵

Wright and Graham go on at great length to castigate the legislatures and the courts for their protection of psychotherapist communications as distinguished from other communications for medical purposes.²⁰⁶ They find the singling out of such communications to be a product of intense lobbying by mental health professionals rather than a recognition of a meaningfully separate category.²⁰⁷

C. Conclusion

As in most legal debates of substance, there are strengths and weaknesses in the arguments on each side. Rather than separately debating each of the points, it is perhaps more useful to look at cases decided in the federal courts. In doing this, the courts should determine, first, whether the existence of a physician-patient privilege would have made a difference either in the outcome of the case or in the impact of disclosure on the physician-patient relationship, and, second, whether the protection of the information from disclosure is justified on policy grounds. Such an analysis is done in the next section.

204. *Id.* at 84.

205. *Id.* at 86 (footnote omitted).

206. *Id.* at 88–139.

207. *Id.* at 93–94.

III. WHAT DIFFERENCE WOULD THE EXISTENCE OF A PHYSICIAN-PATIENT PRIVILEGE HAVE MADE IN FEDERAL COURT CASES?

A. Cases Beyond the Likely Scope of the Privilege or Within a Well-Recognized Exception

The cases in which the federal courts have refused to find the existence of a physician-patient privilege include many instances in which the recognition of the privilege would likely have made no difference at all. Assuming that a physician-patient privilege would have the same parameters as the recognized psychotherapist-patient privilege, the information sought in those cases would either be within a well-recognized exception to the privilege or outside its scope entirely.²⁰⁸

Many of the cases in which parties have sought recognition of a general physician-patient privilege are instances in which the patient's condition is an element of his claim or defense.²⁰⁹ If the

208. The suggested scope of a general physician-patient privilege is discussed *infra* Part IV.

209. See, e.g. *Boddie v. Cranston*, No. 97-3247, 1999 U.S. App. LEXIS 8742, at *1-2 (6th Cir. May 4, 1999) (involving prisoner's claim for damages based on exposure to tuberculosis); *Mann v. Univ. of Cincinnati*, 114 F.3d 1188 (6th Cir. 1997) (sexual harassment claim); *Patterson v. Caterpillar, Inc.*, 70 F.3d 503 (7th Cir. 1995) (finding no privilege where physician did not testify to confidential communications in claim for disability payments under the Employee Retirement Income Security Act (ERISA)); *Sneed v. Jones*, 991 F.2d 791 (4th Cir. 1993) (involving prisoner's claim for mistreatment that included allegations of physical abuse and improper medical treatment); *Hancock v. Dodson*, 958 F.2d 1367, 1373-74 (6th Cir. 1992) (holding, in a claim for injuries under § 1983 civil rights action, that even if state physician-patient privilege law applied, there was a waiver where medical records were released without claiming privilege); *Martin v. Cottrell Contracting Corp.*, No. 7:00-CV-114-F(1), 2000 WL 33177232 (E.D.N.C. Sept. 13, 2000) (involving a personal injury action in admiralty for an accident on navigable waters); *Hingle v. Bd. of Adm'rs of Tulane Educ. Fund*, Civ. A. No. 95-0134, 1995 WL 731696, at *1 (E.D. La. Dec. 7, 1995) (involving a slip and fall case with federal claims under the Family and Medical Leave Act, the Americans With Disabilities Act (ADA) and ERISA as well as supplemental state claims); *Reigel v. Kaiser Found. Health Plan of N.C.*, No. 93-556-CIV-5-F, 1994 WL 660635 (E.D.N.C. Apr. 28, 1994) (involving medical and psychiatric records for a pre-*Jaffee* ADA claim); *Koster v. Chase Manhattan Bank*, No. 81 Civ.5018(GLG), 1984 WL 833, at *1-4 (S.D.N.Y. Sept. 15, 1984) (claiming Civil Rights Act and Equal Pay Act violations with pendent state claims for sexual harassment and holding the records of a gynecologist were properly discoverable as going to plaintiff's claim for damages).

psychotherapist-patient, rather than a general physician-patient privilege had been involved in these cases, the privilege would likely have been rejected, even under the narrowest view of the exception for instances in which the patient has put his or her condition in issue.²¹⁰ In these types of cases, Wigmore's prediction of a narrow application of a general physician-patient privilege is clearly correct.²¹¹

In other instances, the only information that seems to be requested is the identity of the patient and billing information, matters that would not be confidential under the psychotherapist-patient privilege recognized by the federal courts.²¹² In other instances, the government has sought a patient's information where the communications concerned the illegal dispensing of drugs—a criminal transaction likely to come within the crime-fraud exception to the psychotherapist-patient privilege.²¹³

B. The Special Case of Incidental Disclosure of Patient Information

One category in which a general physician-patient privilege might arguably apply deserves special mention largely because the application of the existing psychotherapist-patient privilege is uncertain in these situations. A party, often the government or a *qui tam* plaintiff, may seek a patient's information in connection with an investigation of charges against a physician or other medical provider.²¹⁴ Some of the information sought would be outside the purview of any likely privilege.²¹⁵ As noted above, mere requests for a patient's identity or billing information are unlikely to involve communications of the type protected by the existing

210. See *supra* notes 81–115 and accompanying text.

211. See *supra* text accompanying note 172–174.

212. See *United States v. Moore*, 970 F.2d 48, 50 (5th Cir. 1992); see also *supra* note 62 and accompanying text.

213. See, e.g., *In re Grand Jury Proceedings*, 801 F.2d 1164, 1169 (9th Cir. 1986) (upholding grand jury investigation into illegal dispensing of anabolic steroids and other drugs without a legitimate medical purpose or prescription); *United States v. Witt*, 542 F. Supp. 696, 697, 699 (S.D.N.Y. 1982) (upholding an investigation of clinic allegedly distributing Quaaludes). For a discussion of the crime-fraud exception, see also *supra* text accompanying notes 116–130.

214. See *infra* note 225.

215. *Id.*

psychotherapist-patient privilege.²¹⁶ Often, however, the information sought is somewhat broader; for example, where the party may seek diagnosis or drug prescription data. Such information would, at least indirectly, implicate patient communications and should arguably be protected by either the presently existing psychotherapist-patient privilege or, if recognized, a general physician-patient privilege with the same parameters. Some states adhere to this reasoning and apply a physician-patient privilege to such records.²¹⁷

Where records involving physical, as opposed to mental, conditions are involved, the federal courts have followed a consistent pattern; they reject a common law physician-patient privilege. The appropriateness of the dissemination of the information is instead analyzed as a question of the patient's privacy. Most recently, the issue has been treated as one involving the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations.²¹⁸

The defining case dealing with this question is the United States Supreme Court decision in *Whalen v. Roe*.²¹⁹ Although the question in *Whalen* arose in a slightly different fact pattern from that described above, the Court's treatment of the issue set the tone for future lower court decisions dealing with more usual circumstances.²²⁰ In *Whalen*, the plaintiff challenged the constitutionality of a state statute that created a data bank of the names and addresses of persons obtaining certain drugs by medical prescriptions.²²¹ The Court noted the absence of a common law physician-patient privilege.²²² However, the Court analyzed the claims as if they raised a legitimate question as to protecting the privacy rights of the patients whose data was sought.²²³ The Court

216. See *supra* notes 62 and 212 and accompanying text.

217. See, e.g., *Henry v. Lewis*, 478 N.Y.S.2d 263, 266 (App. Div. 1984); *In re Powell*, 746 N.E.2d 274, 276, 278 (Ill. App. 2001).

218. Pub. L. No. 104-191, 110 Stat. 1936 (1996). For an example of pertinent regulations under HIPAA, see 45 C.F.R. §164.512 (2003).

219. 429 U.S. 589 (1977).

220. *Id.*

221. *Id.* at 591.

222. *Id.* at 602 n.28.

223. *Id.* at 602-06.

upheld the statute, finding that the scheme sufficiently protected the privacy rights.²²⁴

Other pre-HIPAA cases have dealt with the issue in a similar way by applying privacy considerations to limit, but not prevent, access to the information. The courts have provided some qualified protection to the patient but have refrained from labeling that protection a privilege.²²⁵

The HIPAA regulatory scheme recognizes patients' privacy interests but contemplates the disclosure of protected health information in the course of a judicial or administrative proceeding²²⁶ or for law enforcement purposes.²²⁷ Courts asked to consider the question have not been hesitant to find that HIPAA does not codify a general federal physician-patient privilege; nor have they found a limitation on the disclosure of the information in court or grand jury proceedings as provided in the act and regulations.²²⁸

224. *Id.* at 603–05.

225. *See, e.g.*, *United States v. Burzynski Cancer Research Inst.*, 819 F.2d 1301, 1304, 1310 (5th Cir. 1987) (applying privacy considerations but not privilege to the information sought in an action against a doctor for shipment of non-FDA approved anti-cancer drug); *Gen. Motors Corp. v. Dir. of Nat'l Inst. for Occupational Safety Health*, 636 F.2d 163 (6th Cir. 1980) (recognizing absence of physician-patient privilege but considering issue of searching employee records to determine skin disease under *Whalen* to find sufficient assurances against public disclosure); *United States ex rel. Roberts v. QHG of Ind., Inc.*, No. 1:97-CV-174, 1998 WL 1756728 at *1, *8–*9 (N.D. Ind. Oct. 8, 1998) (recognizing that there is no federal physician-patient privilege but considering questions of patient privacy and limiting identifying information on records in a *qui tam* action where plaintiffs sought patient information for their claim against a physician for holding infant patients in intensive care longer than necessary in order to increase billings); *Wei v. Bodner*, 127 F.R.D. 91, 97–98 (D.N.J. 1989) (finding no physician-patient privilege applied in anti-trust action brought by an anesthesiologist against a hospital and that privacy interests could be protected by limiting the information sought); *United States v. Allis-Chalmers Corp.*, 498 F. Supp. 1027, 1029–32 (E.D. Wis. 1980) (finding no physician-patient privilege and that limitations on the use and dissemination of the information adequately protects patients' privacy interests); *see also United States v. Perryman*, 14 Fed. Appx. 328 (6th Cir. 2001) (refusing to apply physician-patient privilege to preclude admission of tests showing defendant had tested positive for drugs in a case involving revocation of a prisoner's supervised release).

226. 45 C.F.R. § 164.512(e) (2003).

227. *Id.* § 164.512(f).

228. *See United States ex rel. Stewart v. The La. Clinic*, No. CIV.A.99-1767, 2002 WL 31819130, at *2–*6 (E.D. La. Dec. 12, 2002) (noting the absence of

The decision in *Northwestern Memorial Hospital v. Ashcroft*²²⁹ illustrates how the federal courts treat this kind of information. In *Northwestern Memorial Hospital*, plaintiffs challenged the constitutionality of the Partial Birth Abortion Ban Act of 2003,²³⁰ which prohibited certain abortion procedures.²³¹ The defendant Department of Justice subpoenaed medical records of patients on whom a particular physician had performed a type of late-term abortion.²³² The lower court quashed the subpoena based upon its recognition of a physician-patient privilege that would apply to medical records dealing with abortions.²³³ The district court analogized the abortion decision to communications between psychotherapists and patients, which were protected in *Jaffee*, and found the same need for confidentiality.²³⁴

The Court of Appeals affirmed, but on different grounds.²³⁵ The higher court flatly rejected the application of a *Jaffee*-type privilege for communications involving abortions.²³⁶ It also refused to find that anything in HIPAA or its regulations prevented disclosure of the

a federal physician-patient privilege while interpreting HIPAA regulations); *In re Grand Jury Subpoena*, 197 F. Supp. 2d 512, 514–15 (E.D. Va. 2002) (finding no federal physician-patient privilege and that HIPAA regulations do not protect patient's privacy interests in the face of a legitimate law enforcement inquiry).

229. 362 F.3d 923 (7th Cir. 2004).

230. 18 U.S.C. § 1531 (Supp. 2004).

231. *Id.*

232. *Northwestern Mem'l Hosp.*, 362 F.3d at 924.

233. *Nat'l Abortion Fed'n v. Ashcroft*, No. 04 C 55, 2004 WL 292,079, at *5 (N.D. Ill. Feb. 6, 2004).

234. *Id.* at *6. After noting the Court's recognition of the need for confidentiality in communications between psychotherapists and patients in *Jaffee*, the district court stated:

It can be no less when dealing with a woman, her doctor, and the necessity to make a decision on abortion, issues indisputably of the most sensitive stripe. American history discloses that the abortion decision is one of the most controversial decisions in modern life, with opprobrium ready to be visited by many upon the woman who so decides and the doctor who engages in the medical procedure. An emotionally charged decision will be rendered more so if the confidential medical records are released to the public, however redacted, for use in public litigation in which the patient is not even a party. Patients would rightly view such disclosure as a significant intrusion on their privacy.

235. *Northwestern Mem'l Hosp.*, 362 F.3d at 933.

236. *Id.* at 926.

records.²³⁷ Nevertheless, the court upheld the lower court's quashing of the government's subpoena based upon the hospital's appropriate invocation of the privacy rights of its patient and upon proof that the burden of compliance outweighed the benefit of production.²³⁸ The court found that the government's need for these records in this litigation was slight when weighed against the women's privacy interests, which would be compromised even if the identity of the women were redacted from the records.²³⁹ The court found that the government had failed to adequately articulate a use for the sought records.²⁴⁰ In effect, the court recognized a qualified privilege for these medical records and held that the defendant had not met its burden in overcoming that privilege.²⁴¹ Such a qualified privilege is, of course, very different from the one announced in *Jaffee*.

The issues involved in cases such as *Northwestern Memorial Hospital* can, of course, arise in the context of communications involving mental, as well as physical, ailments. Such a situation is different because of the clear recognition of the psychotherapist-patient privilege in *Jaffee*.²⁴² The courts' treatment of the situation, however, is not likely to be materially different from the way the matter is treated in cases involving information regarding purely physical ailments. An example of such comparable treatment is the case of *A Helping Hand, L.L.C. v. Baltimore County*.²⁴³ In *Helping Hand*, the plaintiffs alleged violations, *inter alia*, of the Americans with Disabilities Act²⁴⁴ in connection with the location of a methadone treatment clinic for heroin addicts.²⁴⁵ They sought a protective order to prevent discovery of medical information pertaining to clinic patients.²⁴⁶ The court held, however, that

237. *Id.* at 925–26. The court held that the HIPAA regulations do not impose state evidentiary privileges, including the Illinois medical records privilege, on suits to enforce federal law such as the action involved in the *Northwestern Memorial Hospital* case.

238. *Id.* at 927–33.

239. *Id.*

240. *Id.* at 930.

241. *Id.* at 933.

242. See *supra* note 66 and accompanying text.

243. 295 F. Supp. 2d 585 (D. Md. 2003).

244. 42 U.S.C. §§ 12101–12213 (2000, Supp. 2001).

245. *Helping Hand*, 295 F. Supp. 2d at 587.

246. *Id.*

the information was not protected under HIPAA.²⁴⁷ Although recognizing the existence of the psychotherapist-patient privilege, the court held that the plaintiff had given no indication that it was entitled to claim that privilege and had therefore not met its burden of establishing its applicability.²⁴⁸ Nevertheless, the court recognized the sensitivity of the information to recovering heroin addicts, and therefore found that the defendants had not shown sufficient need for the information that justified access to the information.²⁴⁹

*Boudreau ex rel. Boudreau v. Ryan*²⁵⁰ is another example of courts using a balancing process rather than an absolute privilege where incidental use of patient records is involved. In *Boudreau*, the plaintiffs brought an action on behalf of developmentally and mentally disabled adults who were allegedly eligible to receive Medicaid services but who had not received such services.²⁵¹ The plaintiffs sought documents from various agencies, including the mental health records of various non-party persons.²⁵² The court refused to apply the psychotherapist-patient privilege, finding that there had been no showing that the records contained confidential communications.²⁵³ The court then permitted some production of the documents finding that the plaintiffs had a legitimate need for the documents in rebutting one of the defendants' claims.²⁵⁴ Production was issued pursuant to a protective order specifying that "no documents shall be produced that contain personally identifiable data of a developmentally disabled person seeking [M]edicaid services."²⁵⁵

The *Helping Hand* and *Boudreau* cases are indicative of the courts' reluctance to find the existence of a psychotherapist-patient privilege in cases involving the indirect use of medical records, whether they involve physical or mental illness and where there is no showing that the records reflect patient communications. Although courts give some protection, there is no absolute privilege. Thus,

247. *Id.* at 592.

248. *Id.*

249. *Id.* at 592-93.

250. No. 00 C 5392, 2001 WL 1001156 (N.D. Ill. Aug. 24, 2001).

251. *Id.* at *1.

252. *Id.* at *1-2.

253. *Id.* at *3-4.

254. *Id.* at *4-5.

255. *Id.* at *5 (quoting the plaintiffs' proposed protective order).

even if a general physician-patient privilege were recognized, a court could still hold it inapplicable where all that is sought are general medical records of patients involved only incidentally in the case. A general physician-patient privilege would need to have different parameters than the existing psychotherapist-patient privilege in order to clearly bring such situations into its ambit.²⁵⁶

C. Instances in Which the Existence of a General Physician-Patient Privilege Might Have Made a Difference

In some instances, refusal to recognize the existence of a general physician-patient privilege has occurred when similar communications to a psychotherapist would have been protected. If actual communications are involved, the policies closely track those involved in the psychotherapist-patient privilege.

Two cases involving direct communications between patient and physician in which the existence of an extended privilege might have made a difference are *United States v. Donley*²⁵⁷ and *United States v. Bercier*.²⁵⁸ In *Donley*, the court makes only a passing reference to its rejection of a general physician-patient privilege.²⁵⁹ Defendant had sought to prevent admission of statements he had made to the physician treating him for a self-inflicted gunshot wound.²⁶⁰ Assuming that the statements did not go to the defendant's mental condition where it is raised as a defense, a court would seem to be bound to protect these same statements under *Jaffee* as if they had been made to a psychiatrist treating the defendant after his attempted suicide.²⁶¹ It seems as likely that defendant/patients would seek the confidence of their treating physicians as they would of their psychiatrists under the same circumstances. As long as the statement may be pertinent to diagnosis or treatment, the same considerations should apply whether the defendant/patient sought physical or psychological treatment.²⁶² It is perhaps easier to see the pertinence

256. See *infra* Part II for a discussion of the wisdom of such an extension.

257. 878 F.2d 735 (3d Cir. 1989).

258. 848 F.2d 917 (8th Cir. 1988).

259. *Donley*, 878 F.2d at 737, n.1.

260. *Id.*

261. See *Jaffee*, 518 U.S. at 1.

262. Presumably, the patient's communication must be pertinent to treatment under the existing psychotherapist-patient privilege. The Court in *Jaffee* held that "confidential communications between a licensed psychotherapist and her

of the patient's statements in the context of psychotherapy. The medical literature, however, makes clear that a full disclosure of the patient's "underlying feelings, goals, and expectations" is important in all physician-patient interactions.²⁶³ Arguably the policy of encouraging interaction in the medical setting applies if the statement may bear to some extent on the patient's treatment.

In *Bercier*, the defendant was prosecuted for involuntary manslaughter after he drove a motor vehicle while intoxicated.²⁶⁴ A key contested issue in the case was whether the defendant was in fact the driver of the vehicle.²⁶⁵ The defendant objected to the introduction of statements he had made to the emergency room physician after the accident "admit[ting] that he had been driving and had hit the steering wheel with his chest."²⁶⁶ The defendant claimed that admission of the statements into evidence violated his physician-patient privilege, but the court rejected the application of a privilege to the statements at issue.²⁶⁷ The same statements made to a psychotherapist would have been protected under *Jaffee* since a general description of the cause of the accident may well have been pertinent to treatment.²⁶⁸

A number of other cases demonstrate how the existence of a general physician-patient privilege would have made a difference, provided that the records in fact reflected communications rather than simply objective information. One such case is *Gilbreath v. Guadalupe Hospital Foundation, Inc.*,²⁶⁹ which arose from a claim brought by the plaintiff for improper dismissal from his federal

patients in the course of diagnosis or treatment" are privileged. 518 U.S. at 15. One basis for excluding a statement from the privilege was where the communication sought regarded a request unrelated to the patient's counseling for alcoholism, but was rather for the address of a detoxification center. This was not a confidential communication. *United States v. Schwensow*, 151 F.3d 650, 657-58.

263. See *supra* note 156 and accompanying text.

264. *Bercier*, 848 F.2d at 918.

265. *Id.*

266. *Id.* at 920.

267. *Id.*

268. The pertinence of general statements of causation to medical treatment is recognized in the hearsay exception for statements made for purposes of medical diagnosis or treatment. FED. R. EVID. 803(4).

269. 5 F.3d 785 (5th Cir. 1993).

job.²⁷⁰ The dismissal was based in large part on an incident in which the plaintiff was charged with shooting his wife and son.²⁷¹ In the course of the federal agency hearing of the plaintiff's claim, the plaintiff's employer sought the medical records relating to the treatment of the wife and son.²⁷² The court upheld enforcement of the subpoena requiring production of the records finding, *inter alia*, no physician-patient privilege protection under federal law.²⁷³ Assuming that the records reflected communications between the patients and their physicians, similar records with regard to their psychiatric treatment would have been privileged under *Jaffee*.

The facts in *Fisher v. City of Cincinnati*²⁷⁴ are even closer to those in *Jaffee*. In *Jaffee*, the Court found that the psychotherapist-patient privilege absolutely protected communications between a police officer and her psychotherapist concerning the shooting death that was the subject of the plaintiff's section 1983 action.²⁷⁵ In *Fisher*, the plaintiff brought a section 1983 action against the city for deadly injuries sustained in an automobile collision with an off-duty police officer.²⁷⁶ He sought medical records from the officer's treatment after the collision, particularly the results of a blood-alcohol test.²⁷⁷ The court held that no privilege protected this information.²⁷⁸ Again, assuming that the medical records in *Fisher* contained communications between the police officer and his physician, there would seem to be little to distinguish the case from the police officer in *Jaffee*—other than the now crucial difference that the communications involved physical rather than mental topics.

IV. DO THE POLICIES EXPRESSED IN *JAFFEE* SUGGEST THE EXTENSION OF THE PRIVILEGE TO COMMUNICATIONS BETWEEN A PATIENT AND PHYSICIANS GENERALLY?

The above cases demonstrate that the existence of a general privilege for communications to physicians, like that extended to

270. *Id.* at 787.

271. *Id.*

272. *Id.* at 787–88.

273. *Id.* at 791.

274. 753 F. Supp. 692 (S.D. Ohio 1990).

275. *Jaffee*, 518 U.S. at 18.

276. 753 F. Supp. at 692.

277. *Id.*

278. *Id.* at 694–95.

communications with psychotherapists under *Jaffee*, would make a difference in the outcome. Does that mean that the psychotherapist-patient privilege should be extended to general physician-patient communications? The policies expressed in *Jaffee* that support the psychotherapist-patient privilege justify an extension of the privilege, but with the limitations that federal courts have read into the psychotherapist-patient privilege.

The psychotherapist-patient privilege has been limited to actual communications between the patient and the therapist in the course of diagnosis or treatment or to notes directly reflecting such communications.²⁷⁹ Even though psychotherapy is involved, where the information sought involves objective patient information rather than communications from the patient, the courts have tended to treat the matter as one of privacy and have balanced the need for the information against the patient's interests instead of applying the absolute privilege announced in *Jaffee*.²⁸⁰ If the same parameters were to apply to medical records generally, the results in such cases should be the same.

There should be no absolute physician-patient privilege in these instances, but instead a qualified protection of the patient's confidentiality. In cases in which patient records are relevant only in the course of an investigation of a physician, any disclosure is indirect, making the chilling effect of potential disclosure more remote. Patient privacy is implicated, and thus the concerns raised by *Imwinkelried*²⁸¹ and *Wright and Graham*²⁸² are present, but those considerations can be accounted for without applying an absolute privilege. Such an absolute privilege might well limit the disclosure of valuable information in the judicial process without a concomitant benefit to the patient. The treatment of the issue by the courts under the present state of the law seems to appropriately focus on those privacy concerns.²⁸³ Access to the records is limited both in the nature of the information and in its dissemination based on such concerns.²⁸⁴ Similarly, Congress and the federal regulators have

279. For a discussion of the limitations, see *infra* Parts I.C–I.H.

280. See *supra* text accompanying notes 243–255.

281. See *supra* notes 194–201 and accompanying text.

282. See *supra* notes 202–207 and accompanying text.

283. See *infra* Part II.B.

284. *Id.*

spoken on the issue and have provided some protection through the HIPAA regulatory scheme, leaving to the courts considerable room for disclosure as necessary to the judicial process.²⁸⁵ Such a result is consistent with the policies expressed in *Jaffee*, where the concern was for confidentiality of communications.²⁸⁶ The courts may elect, based upon the policies of HIPAA, to give more protection than is now commonly given, but the protection should be less than absolute.

Even where the patient is directly involved in the litigation, the same considerations apply where only the results of tests or similar objective information is sought. Even though the patient's interest is involved, the policy that suggests a qualified rather than an absolute privilege is the same. For example, in *Fisher v. City of Cincinnati*,²⁸⁷ the court could have found that the policies of *Jaffee* were not implicated if the request for medical records was limited to blood-alcohol test results rather than the patient's communications with her physician concerning that test. The party's privacy rights are not implicated to the same extent as they would be if the substance of his *communications* were sought. The results of objective tests in cases like *Gilbreath v. Guadalupe Hosp. Found. Inc.*²⁸⁸ should be treated the same—under qualified but not absolute protection.

But where the information sought involves communications between doctor and patient, whether for treatment of physical or mental infirmities, the absolute privilege should apply. *Jaffee* involved the disclosure of the actual communications of the patient to her psychotherapist.²⁸⁹ Allowing such disclosure might have had a chilling effect on the patient's willingness to communicate fully. That same chilling effect may well result from disclosure of information relevant to physical illness also. Medical scholars and clinicians emphasize that treatment of physical illness should involve more than physical examination and diagnostic tests.²⁹⁰

In cases like *United States v. Donley* and *United States v.*

285. See 45 C.F.R. § 164.512 (2003).

286. 518 U.S. at 15; see also *supra* text accompanying notes 7–9.

287. 753 F. Supp. 692 (S.D. Ohio 1990). See text accompanying *supra* note 262.

288. 5 F.3d 785 (5th Cir. 1993). See *supra* note 269 and accompanying text.

289. 518 U.S. at 15.

290. See *supra* text accompanying notes 155–156.

Bercier, the policies behind the recognition of an absolute privilege seem to be the same as those articulated in *Jaffee*.²⁹¹ For example, *Jaffee* involved statements made by a police officer to a social worker acting as a psychotherapist.²⁹² Assume that the same statements were made to the officer's physician trying to figure out whether stress was causing her back pain. The same need for a full explanation of the stress, including its cause and severity, would exist. Physical ailments may have psychological as well as physical causes. The patient would be reluctant to make that full disclosure if she felt it could be disclosed by the physician in the course of litigation, and there would be a real policy need for absolute confidentiality to protect the privacy of that physician-patient conversation. That it was a general practitioner or orthopedic surgeon looking at a physical ailment, rather than a psychotherapist seeking to treat a mental illness, should make no difference. Courts should consider whether there is any less reason to encourage and protect the confidentiality of such communications than there is in the case of communications to a psychotherapist.

The Court in *Jaffee* emphasized that "[e]ffective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears."²⁹³ The medical literature strongly supports the notion that the physician seeking to deal with physical ailments depends upon the same atmosphere.²⁹⁴

V. CONCLUSION

The medical privilege in the federal courts should apply to communications to general physicians as well as psychotherapists. Despite the Court's dicta to the contrary, the policies articulated in *Jaffee* would be well served by such an extension of the privilege provided it is limited in scope to the same parameters as the existing psychotherapist-patient privilege. The existing privilege is absolute in the areas in which it operates. Different protections of a more qualified kind apply where something other than direct

291. 878 F.2d 735 (3d Cir. 1989); *see supra* note 257-268 and accompanying text.

292. 518 U.S. at 3-4.

293. 518 U.S. at 10; *see also supra* note 8 and accompanying text.

294. *See supra* text accompanying notes 155-156.

communications between medical provider and patient is involved. But communications should have the same absolute privilege whether medical attention is sought for the patient's ego or her elbow.

