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WAIVING THE PHYSICIAN-PATIENT PRIVILEGE IN INVOLUNTARY COMMITMENT PROCEEDINGS IN WASHINGTON—*In re R.*, 97 Wn. 2d 182, 641 P.2d 704 (1982).

On December 16, 1980, a Washington Superior Court Judge found Ms. "R." "gravely disabled"[1] as defined by the Mental Illness Act of 1973[2] and committed her to Western State Hospital for fourteen days of treatment.[3] On December 30, 1980, Western State Hospital filed a petition for an additional ninety days of treatment for Ms. R., alleging that she remained "gravely disabled." At the hearing, the attending psychiatrist gave his opinion of Ms. R.'s mental condition based upon observations and interviews with her.[4] Ms. R.'s attorney objected to the testi-

1. Ms. "R." was originally discovered wandering in traffic and speaking incoherently. She was detained for evaluation, found to be "gravely disabled" under WASH. REV. CODE § 71.05.020, and admitted to Western State Hospital for 72-hour emergency detention. On December 16, 1980, Ms. R.'s detention was extended an additional 14 days. Appellee's Brief at 1, *In re* R., 97 Wn. 2d 182, 641 P.2d 704 (1982).

"Gravely disabled" is defined as "a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety." WASH. REV. CODE § 71.05.020(1) (1981).

"Mental disorder" is defined as "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." *Id.* § 71.05.020(2).

2. WASH. REV. CODE ch. 71.05 (1981).

3. Ms. R. was committed to 14 days detention under WASH. REV. CODE §§ 71.05.230–.240.

WASH. REV. CODE ch. 71.05 (1981) is a detailed and elaborate statute governing the involuntary commitment of people to mental hospitals. Section 71.05.150, which was declared unconstitutional in 1982, states that "[w]hen a mental health professional designated by the county receives information alleging that a person, as a result of a mental disorder, presents a likelihood of serious harm to others or himself, or is gravely disabled," the health professional, upon investigation and evaluation of the alleged facts and the "reliability and credibility of the person" providing the information, may summon the person to appear at an evaluation and treatment facility for a 72-hour period.

Section 71.05.150 was declared unconstitutional by the Washington Supreme Court in *In re* Harris, 98 Wn. 2d 276, 654 P.2d 109 (1982). The court said that § 71.05.150's summons procedure violates constitutional provisions of procedural due process. 98 Wn. 2d at 287, 654 P.2d at 114.

WASH. REV. CODE § 71.05.230 allows the agency providing evaluative services to petition the court for an additional 14 days if it shows that the patient's mental disorder still presents a "likelihood of serious harm to others or himself, or [he] is gravely disabled." The court can grant an additional 14 days of involuntary treatment only after a probable cause hearing held pursuant to § 71.05.240. Section 71.05.240 states that the court must use a preponderance of evidence standard in ruling whether the patient ought to be further detained.

Sections 71.05.280–.310 outline the procedure for 90-day involuntary commitment. Section 71.05.300 states that the patient has the right to a jury trial and § 71.05.310 states that the burden of proof is that of "clear, cogent and convincing evidence." Section 71.05.280 outlines the reasons that justify 90-day detention. Section 71.05.320 outlines the procedure for additional 180-day involuntary treatment.

4. Ms. R.'s psychiatrist testified that Ms. R. was schizophrenic and incapable of meeting her basic needs. Appellee's Brief at 3, *In re* R.

mony, arguing that it was subject to the physician-patient privilege.[5] The judge overruled the objection and ordered further detention.[6]

On March 4, 1982, the Washington Supreme Court sustained the lower court's ruling in *In re R.*,[7] holding: (1) that the statutory waiver of the physician-patient privilege in hearings for fourteen-day involuntary commitment as provided by section 71.05.250 of the Washington Revised Code was also applicable to hearings for ninety-day commitment; and (2) that it was reasonable not to require a non-treating psychiatrist to examine Ms. R. The second holding is critical for two reasons. First, it changes Washington law concerning the psychiatrist-patient relationship in involuntary commitment proceedings.[8] Second, it narrows the applicability of the physician-patient privilege in involuntary commitment proceedings.[9]

In analyzing the court's decision in *In re R.*, this Note will first review the physician-patient privilege. Next, it will assess the court's analysis and application of the statutory waiver in section 71.05.250 of the Washington Revised Code to hearings for ninety-day commitment. This Note concludes that while the court correctly applied the statutory waiver to hearings for ninety-day commitment, the court's standard of reasonableness in applying the waiver of the privilege in this case was improper. Because the physician-patient privilege is a valuable tool in encouraging patients to seek therapeutic treatment, this Note recommends that the courts require a strong showing of necessity before allowing the exercise of the statutory waiver of the privilege.

I. LEGAL BACKGROUND

A. *The Purpose of the Physician-Patient Privilege*

The purpose of the physician-patient privilege is to encourage the free

5. WASH REV CODE § 5.60.060(4) (Supp. 1982) states: "A regular physician or surgeon shall not, without the consent of his patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him to prescribe or act for the patient . . . ." Ms. R.'s attorney asserted that the psychiatrist's testimony was based on information he obtained from Ms. R. after a physician-patient relationship had been established and treatment begun. *In re* R., 97 Wn. 2d 182, 183–84, 641 P.2d 704, 705 (1982).

6. The judge's stated reasons for overruling the objection were that: "(1) [Ms. R.] had waived the physician-patient privilege because she had been given notice by the doctor that her conversation with him might be used in proceedings under RCW 71.05; and (2) that the waiver of the physician-patient privilege was 'necessary to effectuate the ends of that chapter in the best interests of [Ms. R.] and the State.' " Appellant's Brief at 12–13, *In re* R.

7. 97 Wn. 2d 182, 641 P.2d 704 (1982). Ms. R.'s attorney also argued on appeal that Ms. R.'s constitutional right to privacy in her communication with her doctor had been violated. The Washington Supreme Court rejected this argument, and this Note will not address that issue.

8. *See infra* Part IIIB.

9. *See infra* Part IC.

flow of information between patient and physician so that the patient's sickness may be adequately treated.[10] To that end, forty states and the District of Columbia have enacted a physician-patient privilege.[11]

Courts, however, have tended to construe the statutory privilege narrowly, holding it to be in derogation of the common law.[12] Commentators have vigorously criticized the privilege.[13] As a result, efforts have been

10. *In re* R., 97 Wn. 2d 182, 186, 641 P.2d 704, 706; *see also* State v. Boehme, 71 Wn. 2d 621, 635, 430 P.2d 527, 535 (1967), *cert. denied*, 390 U.S. 1013 (1968); State v. Fackrell, 44 Wn. 2d 874, 877, 271 P.2d 679, 681 (1954); State v. Miller, 105 Wash. 475, 478, 178 P. 459, 460 (1919).

11. ALASKA R. EVID. 504; ARIZ. REV. STAT. ANN. § 12-2235 (1982); ARK. STAT. ANN. § 28-1001, UNIF. R. EVID. 503 (1979); CAL. EVID. CODE §§ 990–1007 (West 1966 & Supp. 1981); COLO. REV. STAT. § 13-90-107(d) (Supp. 1982); DEL. UNIF. R. EVID. 503; D.C. CODE ANN. § 14-307 (1981); GA. CODE ANN. § 24-9-40 (1982); HAWAII REV. STAT. tit. 33, ch. 626, HAWAII R. EVID. 504; IDAHO CODE § 9-203(4) (Supp. 1983); ILL. REV. STAT. ch. 110, ¶ 8-802 (1983); IND. CODE § 34-1-14-5 (Supp. 1983); IOWA CODE ANN. § 622.10 (West Supp. 1983–84); KAN. STAT. ANN. § 60-427 (1976); LA. REV. STAT. ANN. § 15:476 (West 1981); ME. R. EVID. 503; MICH. COMP. LAWS § 600.2157 (MICH. STAT. ANN. § 27A.2157 (Callaghan 1976)); MINN. STAT. ANN. § 595.02(4) (West Supp. 1983); MISS. CODE ANN. § 13-1-21 (Supp. 1982); MO. ANN. STAT. § 491.060(5) (Vernon Supp. 1983); MONT. CODE ANN. § 26-1-805 (1981); NEB. REV. STAT. § 27-504 (1979); NEV. REV. STAT. § 49.215–.245 (1981); N.H. REV. STAT. § 329:26 (Supp. 1981); N.J. STAT. ANN. § 2A:84A-22.2 (1976); N.Y. CIV. PRAC. LAW § 4504 (McKinney Supp. 1982-83); N.C. GEN. STAT. § 8-53 (1981); N.D. R. EVID. 503; OHIO REV. CODE ANN. § 2317.02(B) (Page 1981); OKLA. STAT. ANN. tit. 12, § 2503 (West Supp. 1983); OR. R. EVID. 504-1; PA. CONS. STAT. ANN. tit. 42, § 5929 (Purdon 1982); R.I. GEN. LAWS § 5-37.3-4 (Cum. Supp. 1982); S.D. CODIFIED LAWS ANN. §§ 19-13-6 to -11 (1979); TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.08 (Vernon Supp. 1982–83); UTAH CODE ANN. § 78-24-8(4) (1977); VT. STAT. ANN. tit. 12, § 1612 (Supp. 1983); VA. CODE § 8.01-399 (1977); WASH. REV. CODE § 5.60.060(4) (Supp. 1982); WIS. STAT. ANN. § 905.04 (West Supp. 1983–84); WYO. STAT. § 1-12-101(a)(i) (1977).

Of those states that do not have a physician-patient privilege, five have psychiatrist-patient privileges: ALA. CODE § 34-26-2 (Supp. 1982); CONN. GEN. STAT. ANN. § 52-146(d) (West Supp. 1983); KY. REV. STAT. § 421.215 (1978); MD. CTS. & JUDIC. PROC. ANN. § 9-109 (1980); TENN. CODE ANN. § 24-1-207 (1980). Three other states without a physician-patient privilege have a psychotherapist-patient privilege: FLA. STAT. ANN. § 90.503 (West 1979); MASS. ANN. LAWS ch. 233, § 20B (Michie/Law. Co-op. 1975 & Supp. 1983); N.M. R. EVID. 504. Only two states—South Carolina and West Virginia—have none of the above statutory privileges.

12. *See, e.g.*, Randa v. Bear, 50 Wn. 2d 415, 420, 312 P.2d 640, 644 (1957) ("the statute creating the [physician-patient] privilege, being in derogation of the common law, should be construed strictly"); *In re* Dodge, 29 Wn. App. 486, 492, 628 P.2d 1343, 1347 (1981) ("statutory exceptions to the [physician-patient] privilege should be read more broadly than the privilege itself").

Wigmore argues that the physician-patient privilege was not recognized at common law because it meets only the third of his four requirements for recognizing a privilege at common law. 8 J. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2380a, at 829–30 (rev. ed. 1961). Those four requirements are:

(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 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 the litigation.

Id. § 2285, at 527.

13. Saltzburg, *Privileges and Professionals: Lawyers and Psychiatrists*, 66 VA. L. REV. 597,

made to repeal the privilege, but they have met with little success. In general, the Federal Rules of Evidence leave the creation of privileges to the states.[14]

B. *The Distinction Between Treatment and Evaluation*

Courts distinguish between treatment and evaluation in applying the physician-patient privilege because the purpose of the privilege is to encourage and protect only the treatment relationship.[15] Because evaluative examinations are not within the purpose of the privilege, a majority of courts do not apply the physician-patient privilege to information gained by a physician conducting a forensic or evaluative examination.[16]

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617 (1980). Professor Saltzburg gives three reasons why the privilege is so criticized: (1) Few patients would jeopardize their treatment by lying to their physicians out of fear that the information they disclose may be later used against them in court; (2) Few patients even know the privilege exists in the first place; and (3) The privilege has such a narrow scope that its effectiveness is negligible. *Id.*

Professor McCormick has also called for abolishment of the privilege: "[T]he privilege in the main operates not as the shield of privacy but as the protector of fraud. Consequently the abandonment of the privilege seems the best solution." MCCORMICK, HANDBOOK OF THE LAW ON EVIDENCE § 105, at 228 (2d ed. 1972).

These criticisms in general have focused on the doctor-patient relationship rather than the psychiatrist-patient relationship, although the latter is often placed under the physician-patient privilege heading as it was in *In re R.* The reason for making the distinction between a doctor-patient and a psychiatrist-patient relationship is that while courts and commentators are less willing to believe that the physician-patient privilege actually benefits doctor-patient relationships, there is a growing belief that the privilege's protection is necessary for effective psychotherapeutic treatment. *See infra* notes 45–49 & 51–53 and accompanying text.

14. Rule 501 states that the rule of privileges "shall be governed by the principles of the common law as they may be interpreted by the courts of the United States." FED R. EVID 501. Furthermore, the rule states that in civil actions "as to which State law supplies the rule of decision, the privilege of a witness [or] person . . . shall be determined in accordance with State law." *Id.*

In 1975 the United States Supreme Court prescribed Article V of the Federal Rules of Evidence, which contained 13 rules dealing with privileges. Among these rules was a psychotherapist-patient privilege but no physician-patient privilege. FED. R. EVID 501 report of House Committee on the Judiciary. Congress changed this, however, substituting the single Rule 501, which left the law of privileges in its present state. The House Report stated that federal law ought not to "supercede that of the States in substantive areas such as privilege absent a compelling reason." *Id.*. Thus, Rule 501 requires application of state privilege law in proceedings governed by Erie v. Tompkins, 304 U.S. 64 (1938). FED R. EVID 501 report of House Committee on the Judiciary.

15. *In re* R., 97 Wn. 2d 182, 186, 641 P. 2d 704, 706 (1982) (citing State v. Boehme, 71 Wn. 2d 621, 635, 430 P.2d 527, 536 (1967), *cert. denied*, 390 U.S. 1013 (1968)); State v. Miller, 105 Wash. 475, 478, 178 P. 459, 460 (1919).

For examples of courts applying the privilege to a treating psychiatrist, see State v. O'Neill, 274 Or. 59, 545 P.2d 97 (1976) (patient held for treatment is entitled to the physician-patient privilege); *In re* Miller, 51 Or. App. 285, 624 P.2d 1100 (1981) (patient's treating physician's testimony is privileged); and People v. Taylor, 618 P.2d 1127 (Colo. 1980) (where patient had orginally sought voluntary treatment and her psychiatrist petitioned the court for a longer detention period, alleging that the patient would no longer remain in the voluntary treatment program, the physician-patient privilege applied.)

16. MCCORMICK, *supra* note 13, § 99, at 214 n.15; *see, e.g.*, Triplett v. Board of Social Protec-

Washington case law also recognizes the distinction between treatment and evaluation.[17] Furthermore, Washington courts have recognized the physician-patient privilege in examinations by non-treating physicians if the patient believed it was for treatment purposes.[18] This standard is a subjective one and illustrates Washington's focus on the patient and his or her perceptions in determining the applicability of the privilege.

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tion, 528 P.2d 563 (Or. App. 1974); Ramer v. United States, 411 F.2d 30 (9th Cir.), *cert. denied*, 396 U.S. 965 (1969).

For examples of courts requiring evidence that the psychiatrist received his or her information while treating the patient before recognizing the privilege's applicability, see State v. Shaw, 106 Ariz. 103, 471 P.2d 715, 718 (1970), *cert. denied*, 400 U.S. 1009 (1971); State v. Boehme, 71 Wn. 2d 621, 635, 430 P.2d 527, 535–36 (1967), *cert. denied*, 390 U.S. 1013 (1968); State v. Sullivan, 60 Wn. 2d 214, 223–24, 373 P.2d 474, 479–81 (1962); and State *ex rel.* Juvenile Dep't v. Martin, 19 Or. App. 28, 526 P.2d 647 (1974), *rev'd*, 271 Or. 603, 533 P.2d 780 (1975). *See also* Orland, *Evidence in Psychiatric Settings*, 11 GONZ. L. REV. 665, 679 (1976) (noting that "[t]he traditional approach distinguishing between the forensic examination and the treating relationship is rational").

17. The leading decision is State v. Sullivan, 60 Wn. 2d 214, 373 P.2d 474 (1962). In *Sullivan*, the Washington Supreme Court held that it was reversible error for a lower court to allow a psychiatrist who had treated the defendant while the defendant was involuntarily committed to testify about statements the defendant had made to him during the period of examination and treatment. The court said that since the psychiatrist had treated the patient, the information he obtained was subject to the physician-patient privilege. *Id.* at 224–26, 373 P.2d at 480–81.

The *Sullivan* court based its reasoning in part on an earlier Washington case, State v. Fackrell, 44 Wn. 2d 874, 271 P.2d 679 (1954). The *Fackrell* court had held that the physician-patient privilege did not apply to a witness who had been examined by a doctor for the purpose of establishing the crime of rape, stating that since the witness had received no treatment, the privilege ought not apply. *Id.* at 877–78, 271 P.2d at 680–81.

The *Sullivan* court approved the *Fackrell* court's limitation of the privilege to treating physicians, stating that "the [forensic] examination is not for the purpose of treatment, but for the publication of results." State v. Sullivan, 60 Wn. 2d at 223–24, 373 P.2d at 479; *see also* State v. Thomas, 1 Wn. 2d 298, 95 P.2d 1036 (1939); State v. Winnett, 48 Wash. 93, 92 P. 904 (1907).

18. In Ballard v. Yellow Cab Co., 20 Wn. 2d 67, 145 P.2d 1019 (1944), the patient was injured by a taxicab and taken to a hospital where she was examined by a physician. The patient assumed that the examiner was a staff physician on duty at the hospital. The physician, however, was employed by and made the examination on behalf of the taxicab company. The Washington Supreme Court held that even though the physician examined the patient in a non-treating capacity, the fact that the patient believed she was being examined for treatment purposes was sufficient reason for applying the physician-patient privilege. *Id.* at 71–72, 145 P.2d at 1021–22.

The court justified its reasoning in part by quoting a Missouri court decision:

> "It is not necessary in order to create the relation of physician and patient that he should actually treat the patient. If he makes an examination of the patient, with her knowledge and consent, she believing that the examination is being made for the purpose of treating her, then the relation is created by implication . . . ."

Ballard v. Yellow Cab Co., 20 Wn. 2d at 72, 145 P.2d at 1022 (quoting Smart v. Kansas City, 208 Mo. 162, 105 S.W. 709, 717 (1907)); *see also* Sumpter v. National Grocery Co., 194 Wash. 598, 78 P.2d 1087 (1938) (the privilege applied when a physician who originally had been called in and consulted by the patient's regular physician made a subsequent examination on behalf of the opposing party without the patient's knowledge of any change in the physician's capacity).

C. *The Applicability of the Physician-Patient Privilege in Involuntary Commitment Hearings*

Reported decisions from other states have not considered a statutory waiver of the physician-patient privilege in involuntary commitment proceedings. Courts have split, however, on the general applicability of the physician-patient privilege in involuntary commitment proceedings.[19]

In Washington, the legislature has foreclosed the general question of whether the privilege applies at all to involuntary commitment proceedings. In limited circumstances, section 71.05.250 of the Revised Code of Washington allows the waiver of the privilege in proceedings for fourteen-day involuntary commitment. By permitting the waiver of the physician-patient privilege, the legislature has implied that the privilege applies unless waived.[20]

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19. Courts that deny the applicability of the physician-patient privilege to involuntary commitment proceedings offer several justifications. The first is that the state, acting as parens patriae, has "the power and the duty to promote the interests and welfare of its citizens" by committing people needing treatment. *In re* Sonsteng, 573 P.2d 1149, 1153 (Mont. 1978). The second reason is that the state's police power permits the state, for public safety reasons, to commit persons whose mental disorder may cause injury to themselves or others. *Id.* at 1153–54. With either reason, "the state interests entailed by the two powers necessitate dispensing with the various forms of physician/patient privilege." *Id.* at 1154.

A third reason is that the physician-patient privilege has no application to involuntary commitment proceedings unless the patient first voluntarily consulted the physician, for the purpose of the privilege—encouraging voluntary disclosure—is frustrated by, and has little effect in, involuntary relationships. *In re* Winstead, 67 Ohio App. 2d 111, 425 N.E.2d 943, 945 (1980).

A fourth reason is that since involuntary commitment proceedings are for the benefit of the patient, the privilege is unnecessary. Ordinarily, privileges apply in adversarial proceedings, which are, by their nature, for the benefit of neither party. Privileges are considered necessary to protect the holder of a privilege from improper inquiry and discovery, and to ensure that the holder's rights are protected. Involuntary commitment proceedings, however, are not adversarial and exist for the protection of both the public and patient. This difference greatly reduces the need for the privilege and its value, so long as the patient is accorded "scrupulous due process protection." *In re* R., 97 Wn. 2d 182, 187, 641 P.2d 704, 706 (1982).

Other courts argue that there is therapeutic value in preserving confidentiality in the physician-patient relationship. In People v. Taylor, 618 P.2d 1127 (Colo. 1980), the patient entered a voluntary treatment program at a private hospital. Later her treating psychiatrist filed a certification for Short-Term Treatment at the Colorado State Hospital, alleging that despite her acceptance of voluntary treatment, he believed she might not remain in the voluntary program. The Colorado Supreme Court held that the physician-patient privilege applied, stating that (1) the privilege encourages voluntary treatment, and (2) nothing in the Colorado statutes suggested that the privilege ought not to apply. *Id.* at 1140.

20. WASH REV CODE § 71.05.250 (1981) begins by outlining five rights a detained person has in his or her hearing to determine if a 14-day detention is justified. The five rights specified are:

(1) To present evidence on his behalf;

(2) To cross-examine witnesses who testify against him;

(3) To be proceeded against by the rules of evidence;

(4) To remain silent;

(5) To view and copy all petitions and reports in the court file.

The court in *In re R.* acknowledged that section 71.05.250 of the Washington Revised Code contemplates that non-treating psychiatrists evaluate patients.[21] In order to waive the physician-patient privilege, a court must find that it is unreasonable for a non-treating psychiatrist to evaluate the patient. Thus, the waiver provision also maintains the treatment/evaluation distinction that Washington case law recognizes in physician-patient privilege cases.[22]

Section 71.05.250 applies to proceedings for fourteen-day commitment. There is no comparable section in the provisions governing proceedings for ninety-day commitment, though section 71.05.310, which

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Section 71.05.250 then allows for a waiver of the physician-patient privilege with the following provision:

> The physician-patient privilege shall be deemed waived in proceedings under this chapter when a court of competent jurisdiction in its discretion determines that it is unreasonable for the petitioner seeking the fourteen-day involuntary treatment to obtain a sufficient evaluation of the detained person by a psychiatrist or psychologist or other health professional and such waiver is necessary in the opinion of the court to protect either the detained person or the public.

Id.

The waiver's scope is limited, however, by the following provision:

> Whenever the physician-patient privilege is deemed waived pursuant to this section, the waiver shall be limited to the introduction of relevant and competent medical records or testimony of an evaluation or treatment facility or its staff, or a facility certified for ninety-day treatment by the department of social and health services or its staff for the purpose of meeting evaluation requirements contained in chapter 10.77 R.C.W. and chapter 71.12 R.C.W.: *Provided however,* That the physician-patient privilege shall not be waived if the physician specifically identifies himself to the detained person as one who is communicating with that person for treatment only: *And provided further,* That the privilege shall not extend to incident reports involving the detained person.

Id.

In addition to the rights spelled out in § 71.05.250, the patient is also guaranteed other rights. Section 71.05.010 states that the patient's individual rights in involuntary commitment proceedings shall be protected and legal disabilities arising from the commitment eliminated. Section 71.05.060 states that a person who is detained under WASH. REV. CODE ch. 71.05 "shall not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided in this chapter." Section 71.05.360 states that "[e]very person involuntarily detained or committed under the provisions of this chapter shall be entitled to all the rights set forth in this chapter and shall retain all rights not denied to him under this chapter." Section 71.05.450 states that "[n]o person shall . . . lose any civil rights as a consequence of receiving evaluation or treatment for mental disorder."

21. *In re* R., 97 Wn. 2d 182, 188, 641 P.2d 704, 707 (1982).

22. The treatment-evaluation distinction that Washington case law recognizes in physician-patient privilege cases existed at the time that WASH. REV. CODE § 71.05.250 (1981) was enacted. Thus, the legislature can be attributed with knowledge of this distinction. As noted above, § 71.05.250 is set up so as to only allow waiver of the physician-patient privilege in limited circumstances within the involuntary commitment process. *See supra* note 20 and accompanying text. Thus, § 71.05.250 cannot be read as a total abrogation of the physician-patient privilege's applicability to all future treating psychiatrist-patient relationships. Section 71.05.250 can be read, however, as (1) legislative recognition that the treatment-evaluation distinction exists in Washington; and (2) a measure enacted to abrogate that distinction in limited circumstances, thus acting as a modification, but not elimination, of the treatment-evaluation distinction.

governs proceedings for ninety-day commitment, incorporates the due process guarantees and the evidence rules of section 71.05.250.[23] Thus, in *In re R.*, the Washington Supreme Court had to first consider whether the waiver of the physician-patient privilege in section 71.05.250 is applicable to ninety-day commitment hearings under section 71.05.310 before deciding how the waiver should be applied.

II. THE COURT'S REASONING

In *In re R.*, the court held: (1) that the provision in section 71.05.250 for waiver of the physician-patient privilege in proceedings for fourteen-day involuntary commitment was incorporated into the provisions governing involuntary commitment for ninety days; and (2) that exercising the waiver in this case was appropriate because requiring a non-treating physician to examine Ms. R. was unreasonable.[24]

The court asserted that the waiver provision of section 71.05.250 is "adaptable to other [involuntary] proceedings."[25] Citing the reference to section 71.05.250 that appears in section 71.05.310,[26] the court concluded that "[i]n providing that the 90-day extension hearing shall accord with the rules of evidence pursuant to R.C.W. § 71.05.250, the legislature did not exclude the provision for waiver of the physician-patient privilege."[27]

In applying the waiver of the physician-patient privilege to hearings for ninety-day commitment, the court stated that the purposes of the privilege and the waiver are the same.[28] The court noted that the purpose of the privilege is to benefit the patient by encouraging the free flow of information between patient and physician so that the patient's sickness may be adequately treated.[29] The waiver of the privilege is also designed to benefit the patient by facilitating treatment.[30] The court specifically mentioned

23. WASH REV. CODE § 71.05.310 (1981) states in pertinent part: "The person shall be present at such proceeding, which shall in all respects accord with the constitutional guarantees of due process of law and the rules of evidence pursuant to R.C.W. 71.05.250."

24. *In re* R., 97 Wn. 2d 182, 189, 641 P.2d 704, 707–08 (1982).

25. *Id.* at 186, 641 P.2d at 706.

26. *See supra* note 23 and accompanying text.

27. *In re* R., 97 Wn. 2d 182, 186, 641 P.2d 704, 706 (1982).

28. *Id.* The court chose to incorporate WASH. REV CODE § 71.05.250 into § 71.05.310 by following what it called the "spirit of the law." *In re* R., 97 Wn. 2d at 187, 641 P.2d at 707. In other words, where there are two or more possible interpretations of a statute's meaning, the one which best furthers the legislature's intent and purpose ought to be followed. *Id.* (citing Hart v. People's Nat'l Bank, 91 Wn. 2d 197, 588 P.2d 204 (1978)).

29. *In re* R., 97 Wn. 2d at 186, 641 P.2d at 706 (citing State v. Boehme, 71 Wn. 2d 621, 430 P.2d 527 (1967), *cert. denied*, 390 U.S. 1013 (1968)); State v. Miller, 105 Wash. 475, 178 P. 459 (1919).

30. *In re* R., 97 Wn. 2d at 187, 641 P.2d at 707.

at least one way that the waiver is beneficial to the patient: given the difficulty of diagnosing mental illness, the waiver of the physician-patient privilege may make it easier for the petitioner to meet its burden of proof in detaining the patient for further treatment. Without the waiver, persons in serious need of treatment may be dismissed from a mental hospital.[31]

The court denied that the waiver of the physician-patient privilege in involuntary commitment hearings will make patients more reluctant to confide in the psychiatrists who treat them.[32] The court reasoned that involuntarily committed patients, already "hospitalized against their will [and] unable to recognize their need for help," are likely to resist treatment and confidences associated with it in any event.[33] Thus, the court noted that the privilege is of little value in such circumstances.[34]

Holding that section 71.05.250 of the Washington Revised Code does apply to hearings seeking ninety-day detention, the court also held that section 71.05.250 did not require that a non-treating psychiatrist evaluate Ms. R. The court held that an evaluation by a non-treating psychiatrist in this case was unreasonable for two reasons. First, a treating physician is often much more able to testify about the patient's condition than one who conducts a simple evaluative examination; the symptoms of mental illness tend to be sporadic rather than continuous.[35] Second, the court agreed with Western State Hospital's assertion that prohibiting treating psychiatrists from testifying would be an "irrational use of . . . resources."[36] The hospital had argued that the bifurcation of psychiatric duties between treating and non-treating psychiatrists would reduce treatment time for each patient.[37]

III. ANALYSIS

Although the court correctly held that the waiver of the physician-patient privilege in hearings for fourteen-day commitment also applied to hearings for ninety-day commitment, the court allowed the waiver provision to be incorrectly used in *In re R.* by applying an inappropriate standard of reasonableness under the statute. The court reached its conclusion based upon two false assumptions: first, that the physician-patient privi-

31. *Id.* at 188, 641 P.2d at 707.
32. *Id.* at 187, 641 P.2d at 706–707.
33. *Id.*
34. *Id.*
35. *Id.* at 188, 641 P.2d at 707.
36. *Id.*
37. *Id.* Because the Hospital's entire staff is used in the treatment of patients, a bifurcation of duties would put treatment personnel in evaluative positions and force them to review other treating psychiatrists' cases.

lege has little value in cases such as *In re R.*;[38] and, second, that the exercise of the waiver in circumstances like those in *In re R.* is beneficial to the patient.[39]

A. *Waiver of the Physician-Patient Privilege Under Section 71.05.250*

Section 71.05.250 of the Revised Code of Washington states that before the privilege is waived, a court must determine: (1) "that it is unreasonable for the petitioner seeking fourteen-day involuntary treatment to obtain a sufficient evaluation of the detained person"; and (2) "[that] such a waiver is necessary in the opinion of the court to protect either the detained person or the public."[40]

1. *Satisfying the Waiver Provisions in Section 71.05.250—The Reasonableness Test*

The court's holding that it is unreasonable to require non-treating physicians to evaluate patients like Ms. R. was based in part on two assertions that do not withstand analysis: (1) that treating psychiatrists are in a better position to testify about a patient than evaluating psychiatrists;[41] and (2) that any bifurcation of psychiatric duties between treating and non-treating psychiatrists would require a reduction in both the number of treating personnel[42] and the amount and quality of professional time that each patient would receive.[43]

The Washington Supreme Court accepted the first assertion although acknowledging that the bifurcation of duties between treating and non-

38. *Id.*

39. *Id.* at 186, 641 P.2d at 706.

40. WASH REV CODE § 71.05.250 (1981).

41. *In re* R., 97 Wn. 2d 182, 188, 641 P.2d 704, 707 (1982). As mentioned, the court stated that mental illness tends to be sporadic, which puts a treating physician in a better position to testify about a patient than an evaluative physician. *See supra* note 35 and accompanying text. The court did not state in its opinion, however, whether there was any evidence to indicate that Ms. R.'s mental illness was in fact sporadic. The state's brief made no such assertion either. If the court is going to waive the physician-patient privilege and allow treating psychiatrists to testify because mental illness tends to be sporadic, then it would seem reasonable to require a showing that the case at hand is one that involves a sporadic mental illness before exercising the waiver.

Of course, there would not have been an issue here had Ms. R. been evaluated by a non-treating physician, for, as mentioned, Washington case law does not afford any application of the physician-patient privilege to such circumstances. *See supra* notes 17–18 and accompanying text. Ms. R. was evaluated and testified against, however, by her treating psychiatrist. The court stated that it was not necessary for a non-treating psychiatrist to have evaluated Ms. R., agreeing with Western State Hospital that such a requirement is unreasonable. *In re* R., 97 Wn. 2d at 189, 641 P.2d at 708.

42. *Id.*

43. *Id.*

treating psychiatrists is done at other Washington mental health institutions.[44] This fact suggests that some health officials believe that non-treating psychiatrists can adequately evaluate patients and determine those who need to be detained for further treatment.

With respect to the second assertion, it is uncertain that any bifurcation of duties would necessarily reduce treatment time, for the time a treating psychiatrist would gain by being relieved of evaluative duties, such as testing and testifying in court, ought to approximate the amount of treatment time lost by making some treating psychiatrists evaluators.

The argument against the bifurcation of treating and non-treating psychiatric duties assumes that any reduction in the amount of treatment time would mean a corresponding reduction in the effectiveness and quality of the treatment. This assumption is offset by a large body of legal and medical research, which indicates that the opportunity for effective therapeutic treatment is severely limited when a treating psychiatrist cannot guarantee confidentiality.[45] Guaranteeing confidentiality in the psychiatrist-patient relationship improves the quality of treatment enough to compensate for any reductions in treatment time due to the bifurcation of psychiatric duties.

The Washington Supreme Court has acknowledged the importance of protecting confidentiality in the psychiatrist-patient relationship. In *State v. Sullivan*,[46] the court incorporated the following often-quoted rationale from *Taylor v. United States*:[47]

> In regard to mental patients, the policy behind such a statute is particularly clear and strong. Many physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a psychiatrist must have his patient's confidence or he cannot help him. "The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. . . . It would be too much to expect them to do so if they knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to the whole world from a witness stand."

Psychiatrists have long asserted the necessity of confidentiality in the

44. King County Hospital is one such example. *Id.* at 188, 641 P.2d at 707.
45. *See infra* notes 46–49 and accompanying text.
46. 60 Wn. 2d 214, 225, 373 P.2d 474, 480 (1962).
47. 222 F.2d 398, 401 (D.C. Cir. 1955) (quoting M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952)).

psychiatrist-patient relationship.[48] Confidentiality is particularly important between the treating psychiatrist and the involuntarily committed patient. Usually, the psychiatrist explains to an involuntarily committed patient that he or she, the psychiatrist, had nothing to do with the commitment. The psychiatrist does this in order to deflect any anger or anxiety arising from the patient's commitment. Next, the psychiatrist explains to the patient that since the state will detain the patient until he or she responds to treatment, he or she should try to establish the type of treatment relationship that will help the patient return to society.[49] But if the patient also knows that everything he or she reveals to the psychiatrist may later be disclosed publicly, then the incentive to seek treatment is greatly reduced.

By allowing the patient's treating psychiatrist to testify without giving proper respect to the physician-patient privilege, the court has created the potential for less effective treatment of the involuntarily committed patient. Less effective treatment results in longer periods of detention for the patient in mental institutions. This frustrates the legislature's purpose in enacting chapter 71.05 of the Washington Revised Code: to provide "prompt evaluation and short term treatment of persons with serious mental disorders."[50]

A major flaw in the court's analysis is that it failed to consider the fact that the relationship between Ms. R. and her psychiatrist is more than just a doctor-patient relationship. It is a psychiatrist-patient relationship, too. In the past, when the court stated that the physician-patient privilege

48. One commentator describes the literature arguing the need for confidentiality in the psychotherapeutic relationship as "massive." Orland, *supra* note 16, at 677 n.59.

Surveys conducted attempting to verify empirically the arguments in support of the psychiatrist-patient privilege have been inconclusive. *See, e.g.*, Shuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C.L. REV 895 (1982); Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN L. REV 165 (1978); Note, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226 (1962). The results of most surveys are that there is no real empirical evidence that shows that "elimination or restriction of the privilege would seriously affect the profession; nor is there evidence that people are deterred from seeking help in states where there is no privilege." Note, *The Scope of the Psychologist-Patient Testimonial Privilege in Utah*, 1980 UTAH L. REV 385, 387. But such studies themselves may be seriously flawed, because the testing for evidence of the importance of deterrence or confidentiality is extremely difficult to prove or disprove empirically. Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL L. REV. 1025, 1039 n.63 (1974). In addition to the issue of confidentiality, many other factors are involved in the decision to seek treatment. Two commentators assert that empirically testing the efficacy of the psychotherapist-patient privilege is "as elusive of determination as the deterrent impact on crime of any specific penalty." *Id.*

49. Orland, *supra* note 16, at 676–77.

50. WASH REV CODE § 71.05.010(2) (1981).

ought to be construed strictly since it is in derogation of the common law, it was dealing with cases involving doctor-patient relationships.[51]

Such a narrow construction of the privilege, however, has not been applied to cases involving a psychiatrist-patient relationship. The *Sullivan* decision[52] illustrates how the courts have liberally applied the privilege to treating psychiatrist-patient relationships.[53]

2. *Satisfying Section 71.05.250's Waiver Provisions—The Benefit of the Waiver*

The court concluded that the waiver of the physician-patient privilege benefits the involuntarily committed, while the privilege itself is of "little value."[54] But these conclusions contradict the views of many legal and medical scholars.[55] It is not disputed that the waiver of the physician-patient privilege in section 71.05.250 was designed for the patient's bene-

51. *See, e.g.*, Department of Social and Health Servs. v. Latta, 92 Wn. 2d 812, 819–20, 601 P.2d 520, 525 (1979) (privilege held to be inapplicable to subpoena of medical records of Medicaid patients for auditing purposes); State v. Boheme, 71 Wn. 2d 621, 634–37, 430 P.2d 527, 536 (1967), *cert. denied*, 390 U.S. 1013 (1968) (rape victim unsuccessfully attempted to exercise privilege in the criminal trial of the alleged rapist); Randa v. Bear, 50 Wn. 2d 415, 420, 312 P.2d 640, 644 (1957) (patient suing hospital on medical service contract waived the privilege as to medical records of patient's ailments kept by the hospital).

52. State v. Sullivan, 60 Wn. 2d 214, 373 P.2d 474 (1962), discussed *supra* at notes 17 & 46–47 and accompanying text.

53. Other courts, too, have been very liberal in protecting the psychiatrist-patient relationship. In Allred v. State, 554 P.2d 411 (Alaska 1976), the Alaska Supreme Court, using Wigmore's four-part test for whether a privilege exists at common law, J. WIGMORE, *supra* note 12, at 829–30, held that there is a common law privilege for a psychiatrist-patient relationship. *Allred*, 554 P.2d at 417. Said the court: "Reason indicates that the absence of a privilege would make it doubtful whether either psychotherapists or their patients could communicate effectively if it were thought that what they said could be disclosed compulsorily in a court of law." *Id.* at 418.

The California Supreme Court in *In re* Lifschutz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970), held that the psychiatrist-patient privilege has constitutional underpinnings. Also of significance, the court stated:

> Even commentators who concurred in the criticism of the general physician-patient privilege noted that the psychotherapeutic privilege rested on a much sounder basis . . . . The differences that exist between these two medically oriented privileges caution against blind application of the precedents of the physician-patient privilege in future psychotherapist-patient privilege cases.

Id. at 434 n.20, 467 P.2d at 570 n.20, 85 Cal. Rptr. at 842 n.20.

California courts have also stated that the psychotherapist-patient privilege ought to be liberally construed in the patient's favor. Roberts v. Superior Court, 9 Cal. 3d 330, 337, 508 P.2d 309, 313, 107 Cal. Rptr. 309, 313 (1973); *see also In re* B., 482 Pa. 471, 394 A.2d 419, 425 (1978) ("[w]e conclude that in Pennsylvania, an individual's interest in preventing the disclosure of information revealed in the context of a psychotherapist-patient relationship has deeper roots than the Pennsylvania doctor-patient privilege statute, and that the patient's right to prevent disclosure of such information is constitutionally based").

54. *In re* R., 97 Wn. 2d 182, 187, 641 P.2d 704, 706 (1982).

55. *See supra* notes 46–49 and accompanying text.

fit. The issue, however, is the type of treatment that results by improperly allowing the waiver of the privilege in a treating psychiatrist-patient relationship. Waiver of the privilege in a treatment relationship often may do more harm than good to the patient by reducing the chance for effective treatment.

When a court applies the reasonableness test of section 71.05.250[56] consistent with the respect for the psychiatrist-patient relationship shown in prior decisions, the patient is accorded maximum benefit. The reasonableness test should also be applied consistently with the large body of legal and medical evidence arguing that confidentiality is beneficial to the treating psychiatrist-patient relationship. Thus, a strong showing of necessity should be required before waiving the privilege.

3. *A Proposed Test for Applying the Waiver Provision of Section 71.05.250*

The waiver is designed to benefit the patient. Accordingly, the waiver of the physician-patient privilege in a treating psychiatrist-patient relationship should only be allowed when the following two conditions are met. First, an evaluative psychiatrist must testify that he or she is unable to make an adequate assessment of the patient for lack of treatment records or history, or because the patient's illness is unduly sporadic. Second, the patient's treating psychiatrist must be willing to testify against the patient and sign an affidavit stating that waiver of the privilege in this particular case would not harm the psychiatrist-patient relationship.[57] Such a test would protect the treatment relationship by permitting the waiver when the patient's interests—both medical and legal—would best be served. At the same time, the state would still have the necessary means for evaluating and committing patients who need treatment, thus protecting the state's interests in the matter. With both results, the patient is benefited.

The court correctly held that section 71.05.250's waiver provision in hearings for fourteen-day commitment should be applicable to hearings for ninety-day commitment as well.[58] As a corollary, section 71.05.250's

56. *See supra* Part IIIA*1*.

57. Of course, the patient should be granted the opportunity to rebut the psychiatrist's testimony.

58. Without the incorporation of WASH REV CODE § 71.05.250 into § 71.05.310, there would have been no statutory authority for waiving the privilege in 90-day hearings. By ruling that § 71.05.250 is incorporated into § 71.05.310, however, the court could then decide whether § 71.05.250's waiver provisions were satisfied and the privilege waived in the case of Ms. R. The court ruled correctly in incorporating § 71.05.250 into § 71.05.310. Section 71.05.250 is easily adaptable to other hearings, and there is no indication that the legislature intended its waiver provisions to apply

contemplation that evaluations be conducted by non-treating psychiatrists, as well as the principles involved in deciding whether section 71.05.250's waiver of the physician-patient privilege ought to be allowed, should also be applicable to hearings for ninety-day commitment.

Thus, section 71.05.250's two-part test for determining whether the waiver of the physician-patient privilege should be allowed was not met on either account: (1) it is not unreasonable to require that non-treating psychiatrists evaluate patients; and (2) the waiver benefits the patient most when a court gives the physician-patient privilege adequate weight and considers the respect accorded the psychiatrist-patient relationship by Washington case law. The privilege should only be waived in treatment relationship cases when the patient's evaluative and treating psychiatrists testify that non-treatment evaluation is impossible and waiving the privilege will not harm the patient.

It is unfortunate that part of the reason the court waived the physician-patient privilege in *In re R.* was because of Western State Hospital's manpower problems. This is in flagrant violation of the legislature's intent in enacting chapter 71.05 of the Washington Revised Code: to safeguard individual rights.[59] In this case, Ms R.'s legal right—the right to the physician-patient privilege—was sacrificed in part because of one hospital's staffing problems.

B. *Result of the Decision*

The court's lax standard for waiver of the physician-patient privilege allows a treating psychiatrist broad latitude to testify against a mental pa-

only in 14-day commitment hearings and not 90-day hearings. *In re* R., 97 Wn. 2d 182, 186, 641 P.2d 704, 706 (1982).

The court said it followed the "spirit of the law" over the "letter of the law" in holding that § 71.05.250 is applicable to and incorporated into § 71.05.310. *In re* R., 97 Wn. 2d at 187–88, 641 P.2d at 707. Not only may this be the "spirit of the law" but it seems to be the "letter of the law," too, since § 71.05.310 does say that the rules of evidence in § 71.05.250 shall apply.

The court, however, failed to follow its "spirit of the law" guideline with respect to the rest of its decision. Already mentioned was the court's acknowledgment but refusal to hold what WASH. REV. CODE § 71.05.250 contemplates—that non-treating physicians conduct the evaluative examinations. *In re* R., 97 Wn. 2d at 188, 641 P.2d at 707. If the "spirit of the law" had been followed, the court would have given effect to what § 71.05.250 contemplates. Unfortunately and inconsistently, the court did not do this. Moreover, based upon past Washington Supreme Court decisions strongly supporting the physician-patient privilege, *see* State v. Boheme, 97 Wn. 2d 621, 635, 430 P.2d 527, 535 (1967), *cert. denied,* 390 U.S. 1013 (1968); State v. Sullivan, 60 Wn. 2d 214, 224–26, 373 P.2d 474, 480–81 (1962); State v. Fackrell, 44 Wn. 2d 874, 877, 271 P.2d 679, 681 (1954); State v. Miller, 105 Wash. 475, 478, 178 P. 459, 460 (1919), and the evidence supporting the need for the physician-patient privilege in the psychiatric treatment relationship, *see supra* notes 45–49 and accompanying text, following the "spirit of the law" here would certainly have required the court to pay more deference to the privilege and not categorically disregard its value and application.

59. WASH. REV. CODE § 71.05.010(3) (1981).

tient in proceedings for fourteen-day and ninety-day commitments. A lax application of the waiver provision of section 71.05.250 of the Washington Revised Code leaves mental patients virtually without recourse to the physician-patient privilege in proceedings for fourteen-day and ninety-day involuntary commitments.[60] As a result, the patient has the "scanty . . . and ineffective"[61] protection of only "weakly worded ethical canons of the medical profession,"[62] the Hippocratic Oath,[63] and professional integrity.[64]

IV. CONCLUSION

The court was correct in ruling that section 71.05.310 of the Revised Code of Washington incorporates section 71.05.250. The court's failure to give substance to the waiver requirements of section 71.05.250, however, is contrary to legislative intent, and does injustice to the statute and the legal rights of the mental patient. The court should have limited the waiver and application of section 71.05.250 to non-treating psychiatrists, and to treating psychiatrists only when a patient's evaluating and treating psychiatrists testify that non-treatment evaluation is impossible and waiver of the privilege would not harm the patient. Such a result would have been more consistent with Washington case law concerning the physician-patient privilege and the difference between treating and non-treating physicians. It would also ensure that the state can seek detention of those needing treatment, yet preserve the treatment relationship. This would afford a greater chance for successful and prompt treatment of the patient. Such a result serves all interests involved. Most importantly, it serves the welfare and interests of the patient, which should be paramount.

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60. Even under *In re* R., 97 Wn. 2d 182, 641 P.2d 704 (1982), WASH. REV. CODE § 71.05.250 would still allow the physician-patient privilege to be applicable if the court finds that § 71.05.250's waiver provisions were not satisfied. Also, § 71.05.250's waiver cannot be used in cases where the treating physician "specifically identifies himself to the detained person as one who is in communication with that person for treatment only." *In re* R., 97 Wn. 2d 182, 641 P.2d 704 (1982). Such instances would seem relatively rare.

61. Louisell & Sinclair, *Forward: Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective*, 59 CAL L. REV. 30, 33 (1971).

62. *Id.* at 32–33.

63. "[W]hatsoever I shall see or hear in the course of my profession as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." *Id.* at 33 n.15.

64. *Id.* at 33.