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PSYCHIATRIST-PATIENT PRIVILEGE†

By JONAS R. RAPPEPORT, M.D.*

At the 1963 session of the Maryland Legislature a bill will be introduced proposing a legal privilege for the communications between a patient and a psychiatrist.[1] This bill is being presented at the request of the Maryland Association for Mental Health.[2] The model for this proposed bill is the recently approved statute of the State of Connecticut. It is divided into three sections: the first creates the privilege; the second defines the principal terms used; the third sets out the conditions under which the privilege ends. It provides, in full:

"1. Psychiatrist-patient privilege. In civil and criminal cases, in proceedings preliminary thereto, and in legislative and administrative proceedings, a patient, or his authorized representative, has a privilege to refuse to disclose, and to prevent a witness from dis-

† In an article "Confidentiality Between Physician and Patient", 22 Md. L. Rev. 181, 189 (1962), Rignal W. Baldwin, Esq., has spoken as a lawyer against the psychiatrist-patient privilege, saying in part, "The principal pressure for enactment of a statutory privilege appears to come from the psychiatrists and psychologists. In fact a Bill proposing legal privilege of communications between psychiatrists and their patients in Maryland has been prepared for introduction at the 1963 session of the General Assembly. While there may be some reason to separate psychiatrists as a class from surgeons and some specialists, how can they — or rather their patients — logically be singled out for special consideration as against patients of the family physician of the 'old school' or the country doctor, who learns all of the secrets of the entire family? I, for one, emphatically would not change the law toward any such extension of legal privilege but, rather toward restriction of all existing privileges which tend to suppress truth and justice." (Author's footnotes omitted.)

The author of the instant article, as a psychiatrist, has asked the Review for the opportunity to place before its readers the reasons why so many psychiatrists favor legislation establishing the privilege [The Council of Psychiatric Societies, representing the three professional psychiatric groups in Maryland, has gone on record in favor of such a privilege].

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[1] A doctor-patient privilege bill with very broad powers was introduced by the Honorable Jerome Robinson at the 1961 session of the State Legislature when, as the result of some court decisions, he was made aware that there was no doctor-patient privilege in Maryland. (See Leszynski v. Russ, 29 F.R.D. 10 (1961)). This was then referred to the Legislative Council, Item 117.

[2] This organization, Judge Jerome Robinson, President, is the Maryland Chapter of the National Association. This group is composed predominately of lay persons, many lawyers included, who are concerned with the welfare and care of the mentally ill.

closing communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and such persons who participate, under the supervision of the psychiatrist, in the accomplishment of the objectives of diagnosis or treatment.

"2. Definitions. As used in this act, 'patient' means a person who, for the purpose of securing diagnosis or treatment of his mental condition, consults a psychiatrist; 'Psychiatrist' means a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed by the patient to be so qualified; 'authorized representative' means a person empowered by the patient to assert the privilege and, until given permission by the patient to make disclosure, any person whose communications are made privileged by Par. 1 of this act.

"3. Exceptions. There is no privilege for any relevant communications under this act:

(a) when a psychiatrist, in the course of diagnosis or treatment of the patient, determines that the patient is in need of care and treatment in a hospital for mental illness;

(b) if a judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychiatrist in the course of a psychiatric examination ordered by the court, *provided* that such communications shall be admissible only on issues involving the patient's mental condition;

(c) in a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, or after the patient's death, when said condition is introduced by any party claiming or defending through or as a beneficiary of the patient, if the judge finds that it is more important to the interests of justice that the communication be disclosed than that the relationship between patient and psychiatrist be protected."[3]

[3] Goldstein, *Psychiatrist-Patient Privilege: The G.A.P. Proposal and the Connecticut Statute*, 36 Conn. Bar J. 175, 184 (1962). (Published also

Professors Goldstein and Katz, of the Yale Law School, two of the authors of this law, discuss it as follows:

> "Section 1 makes the privilege applicable to all official proceedings to which the patient's communications might be relevant. It protects the patient from the disclosure, without his consent, of all communications made by him or by members of his family to the psychiatrist and to those who assist him in diagnosis or treatment, whether in private office, hospital, clinic or other facility. Communications to clinical psychologists and social workers working with psychiatrists would, therefore, clearly be included. On the other hand, the requirement that the communication relate to diagnosis or treatment leaves unprotected any communications made to a psychiatrist involved in a personnel screening program.
>
> "In Section 2, the patient is anyone who communicates with a psychiatrist for the purpose of diagnosis or treatment, whether it be on an in-patient or out-patient basis, in public or private hospital, public or private clinic, private office or other setting. 'Psychiatrist' is defined to include not only the physician who has been certified by the American Board of Psychiatry and Neurology, but also the physician who, though not certified, is engaged in the practice of psychiatry. It also includes, in the interests of the patient whose confidences are in issue, those persons who are 'reasonably believed by the patient' to be psychiatrists. Moreover, under this section, it is made clear that the privilege is the patient's and that its protection may not be waived by the persons in whom he places his confidence, unless he has given permission to make disclosure.
>
> "Section 3 deals with that most difficult of problems — the point at which it can be said that the value of preserving confidentiality is outweighed by the interest of society in gaining access to the protected communications. After a great deal of discussion, and considerable compromise, our committee agreed upon three general situations in which the privilege was to be treated as terminated. In the

in 118 J. Am. Psych. A 733, 737 (1962)). The statute as enacted is found in 24 CONN. CODE (Cum. Supp. 1961) § 52-146a, approved June 21, 1961. The language is slightly different, but substantively there is no difference.

committee's view, these exceptions dealt successfully with the overwhelming majority of problem situations.

"The first authorizes a psychiatrist to end the privilege to a limited extent when he determines that his patient needs hospitalization. To that end, it incorporates by reference the language of the Connecticut commitment statute. But it is important to note that the privilege is to be terminated only for the purpose of securing hospitalization or instituting commitment proceedings. It remains in force after the patient is hospitalized, so long as he is communicating with psychiatrists and other hospital personnel for the purpose of diagnosis or treatment. Such an exception is essential if the psychiatrist is to perform his role which will, in some instances, require that he use the material supplied by the patient as a basis for hospitalization. There is, however, a restriction on the exception. Only those communications may be disclosed which are *relevant* to the commitment proceeding in which he is asked to testify.

"The second exception deals with the situation, in civil or criminal cases, in which a person is ordered by the court to submit to an examination. This may occur, for example, when a patient claims damages for a mental illness caused by X or when a complaint of sexual molestation is made against X by a patient. In such case, X may request that the patient (now the plaintiff or complaining witness) be examined by a psychiatrist and an examination may be ordered by the court. Under such circumstances, there would be no protection for the statements made in the course of the examination. It is arguable that such an exception need not have been included in this bill, because a patient examined under these facts is not consulting a psychiatrist 'for the purpose of securing diagnosis or treatment of his mental condition'. Nevertheless, it is entirely possible that, if such examination should continue over a period of time, the person examined may not realize the extent to which his statements to the psychiatrist may be made public. To remove any doubt, our committee decided to end the privilege only if the person being examined knew what was transpiring, and if the information elicited would be used *solely* for its bearing upon the patient's mental condition.

> "The third exception proceeds on the assumption that the patient should not be permitted to plead mental illness in civil cases and at the same time be permitted to conceal evidence relevant to that condition. The most obvious illustration is the patient who has a history of psychiatric treatment and who sues for compensation for a new psychiatric disability allegedly caused by the defendant. Under the Connecticut bill, such a patient would find that he had 'waived' his privilege if two important conditions were satisfied: (1) the questions asked of his psychiatrist dealt with communications which are 'relevant' to the current proceeding; and (2) the trial judge concluded, after a discussion specifically directed to the matter, 'that it is more important to the interests of justice that the communication be disclosed than that the relationship between patient and psychiatrist be protected'."[4]

There are thirty seven states with some form of doctor-patient privilege.[5] Many of these statutes are quite limited or have been interpreted or amended so that they offer little in the way of privilege. Others are so broad that they are sometimes abused. Nevertheless, to my knowledge none has ever been completely repealed since the first doctor-patient privilege statute was enacted in New York in 1828.[6] Several states have recently passed doctor-patient privilege legislation — Illinois (1959), Georgia (1959), Connecticut (1961). The Georgia statute[7] simply places communications between the psychiatrist and patient in the same category as those between husband and wife, attorney and client, among grand jurors, and secrets of state. The Connecticut statute, on the other hand, is set up in more detail to avoid the known abuses.[8] I would particularly call the readers' attention to the ex-

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[4] *Id.*, 185-8. This law was developed by a committee of lawyers, doctors, and interested lay leaders of the Mental Health movement. Much educated and serious deliberation was given to each section.

[5] Zenoff, *Confidential and Privileged Communications*, 182 A.M.A.J. 656 (Nov. 10, 1962). The author lists 36 states, but did not include Connecticut.

[6] Slovenko (Assoc. Prof. of Law Tulane Univ. Law School), *The Psychiatrist and Privileged Communications*, 4 Arch. Gen. Psych. 434 (1961).

[7] 13A GA. CODE (Cum. Supp. 1961) Evidence, § 38-418.

[8] Chafee, *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?* 52 Yale L.J. 607 (1943); Slovenko, *op. cit. supra*, n. 6, 434-5.

ceptions clause[9] of the Connecticut act which certainly limits the privilege to serve the ends of justice.

Concern has been expressed that such an act might interfere with the functioning of a court appointed psychiatrist. This danger would seem to me to be taken care of in the proposed bill. It is my standard procedure always to inform the person being examined that the examination is being done for the court and that anything revealed by him might be reported to the court. Dr. Manfred Guttmacher[10] has always done likewise.[11] The New York Court of Appeals has held that evidence obtained by the improper influence of a psychiatrist is inadmissible.[12]

We are concerned lest any special privilege might block the discovery of the truth to such a degree as to interfere with the dispensing of justice. This would certainly be a deplorable thing and is to be avoided at almost all costs. I say "almost", because I think that irreparable damage to the individual would be the one limiting factor, and under such circumstances the best interests of society would be served by protecting the individual. I feel that the type of patient-psychiatrist relationship that we have today meets these criteria. The Group for the Advancement of Psychiatry report says:

> "This Committee believes that confidentiality is essential to psychiatric treatment. This is based on pragmatic grounds as well as on the ancient ethical relationship of physician and patient. It is difficult for this Committee to conceive that the interests of society and justice will be better served by weakening the force of the confidential relationship or by denying privileged communications to psychiatric patients."[13]

In the past 60 years alone the theories and treatments of modern psychiatry have developed to such a degree that they have added words to our daily vocabulary and even

[9] It may be necessary in Maryland to add an exception applicable to the "rehearings" of those previously committed to the Patuxent Institution although Exception C should cover this.

[10] Chief Medical Officer to the Supreme Bench of Baltimore City.

[11] Guttmacher and Weihofen, *Psychiatry and the Law* (Norton, 1952) 274-275.

[12] People v. Leyra, 302 N.Y. 353, 98 N.E. 2d 553 (1951).

[13] Group for the Advancement of Psychiatry, *Confidentiality and Privileged Communication in the Practice of Psychiatry* (Report No. 45, 1960) 93. The G.A.P. has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations.

influenced the practice of law. More and more people are having daily contact with psychiatry either in terms of treatment or in such divergent ways as T.V. and radio shows, etc. Careful inquiry has led me to believe that the general public assumes that communications to the psychiatrist are confidential and privileged. If not, then certainly they would not reveal the things required of them for successful psychiatric treatment.

Mr. Baldwin says that the privilege was given to the husband-wife relationship to "protect and encourage domestic tranquility".[14] What about the patient who consults the psychiatrist because of his guilt over an extra-marital relationship? Does forced violation of such a confidence "protect and encourage domestic tranquility"? The physician's use as a "healer" is cancelled if he is forced to become an unwilling informer to an issue of "fault or blame".[15] The GAP report later says:

> "In recent years there has been an increasing tendency to utilize psychiatric testimony in litigation. Psychiatrists treating patients who have become involved in divorce actions have been subpoenaed to testify as to the 'fault' of the one or the other party, to make recommendations regarding the custody of the children or to other matters related to the divorce action. While psychiatric testimony in some divorce actions can be constructive, in others the absence of privilege probably discourages the use of psychiatry when it might be of real help."[16]

A comparable situation actually occurred in Chicago in 1952.[17] There, Dr. Roy Grinker, an internationally known psychiatrist, refused to testify as to what his patient (the wife in an alienation of affections case) told him. The trial judge not only did not find him in contempt but granted him (as well as the hospital records) privilege even though there was no doctor-patient privilege in Illinois at that time. Since then Illinois has passed a statute creating the doctor-patient privilege.[18]

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[14] Baldwin, *Confidentiality Between Physician and Patient*, 22 Md. L. Rev. 181, 184 (1962).

[15] G.A.P. Report, *op. cit. supra*, n. 13, 92.

[16] *Id.*, 97.

[17] Binder v. Ruvell, Harry Fisher, Judge, Civil Docket 52C2535 (June 24, 1952) Circuit Court for Cook County, Illinois, reported in 150 A.M.A.M. 1241 (1952) and commented upon in 47 Nw. U. L. Rev. 384 (1952).

[18] ILL. CODE (Cum. Supp. 1962) Evidence and Depositions, § 5.1 (I am not sure that there was any direct cause and effect relationship here, but it is likely).

In at least two recent unreported Maryland cases, the courts allowed out-of-state lawyers, against the hospital's objections, the right to scrutinize records of Maryland hospitals and obtain photocopies of these records. In one case a mother lost custody of her children after the court heard a description of her deranged behavior even though she was now considered "well", and certainly as well as her husband[19] who was given custody. In the other case a minister had his confessions of an illicit affair (quite possibly his sick fantasy) from his college days paraded before his parishioners.[20]

Is there any one of us so absolutely pure that he cannot imagine being concerned about revealing some past experience, wish, dream, etc., to someone else? In private practice it has been my experience that patients reveal information that they never would discuss with their lawyer, wife, husband and sometimes even their priest,[21] or minister. The material discussed in this "treatment" situation[22] is such that it would not be brought up in these other relationships. Yet if revealed out of context in a courtroom it could be a most devastating experience.

Professors Goldstein and Katz comment:

> "The patient, however much in need of treatment, is ordinarily reluctant to seek it. This reluctance is traceable not only to the anticipated stigma but also to the tendency of persons considering treatment to see themselves in the worst possible light. Their anti-social impulses, abetted by an inability clearly to differentiate between phantasy and reality, may become magnified beyond all reasonable proportion. Even under optimum conditions of confidentiality, it is difficult for the patient to confide his thoughts and feelings to another person. If, to that difficulty, is added the possibility of disclosure at some future date, it can be expected that he will not speak freely and that his

[19] Testimony by Dr. H. W. Murdock, Medical Director Sheppard & Enoch Pratt Hospital, Towson, Maryland, before a hearing of the Legislative council re: Privileged Communication legislation, Baltimore City Council Chambers, Oct. 3, 1962.

[20] *Ibid.* Testimony by Dr. Irving Taylor, Medical Director Taylor Manor Hospital, Ellicott City, Maryland.

[21] It is my understanding that much of this material would have no actual place in the confessional. Certainly some of it would be looked upon by a priest as excessive scrupulosity; in itself a sin, and the basis for a referral to a psychiatrist by the priest.

[22] The patient is usually seen weekly for 50 minute sessions, sometimes for more than a year. In psychoanalysis, a more intensive type of treatment, the patient is seen 4 times a week for 50 minute sessions for 2 or more years.

concern about the other implications of treatment will be reinforced."[23]

The Court of Appeals, on the basis of "no such privilege at common law", in 1915 said that there was no doctor-patient privilege in Maryland.[24] One cannot help but wonder why there has not been real trouble to date[25] and why the issue is being raised so strongly at this time. The answer to the first question can only be guessed at. I think that we have somehow managed to have an "extra-legal" psychiatrist-patient privilege in Maryland by the courtesy of the courts and the bar. On several occasions since I have been connected with the courts (and Dr. Guttmacher informs me that his experience has been similar) I have received calls from colleagues who have wanted to know what would happen to them if they refused to testify when asked to, under circumstances in which they felt that they would be betraying their patients' confidences. Naturally, I had to tell them that there was no protection for them under the law. What actually happened is that either the lawyer decided not to call the psychiatrist, the "unacceptable" questions were not asked, the judge let them go unanswered, or else the doctor "lost" records or "forgot" certain communications.

Every psychiatrist lives in fear of the day when he will not be as fortunate as this. At this time it might seem to the reader that we have a psychiatrist-patient privilege in a sense, yet it should be obvious that such an "extra-legal" type of privilege is dangerous. It should be noted that in 1957 the Legislature passed a priest-penitent privilege law when it was "discovered" that none existed.[26] Further, there is a present trend in our country to require various types of reports under the name of necessity for tax programs, research, etc. The increase in litigations of all types as well as the increased use of pre-trial discovery procedures, certainly tends to seriously threaten the privacy of the psychiatrist-patient relationship. It seems that

[23] Goldstein, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 Conn. Bar J. 175, 178 (1962).

[24] O'Brian v. State, 126 Md. 270, 94 A. 1034 (1915).

[25] Testimony, *op. cit. supra*, n. 19, Mr. G. C. A. Anderson, Counsel for the Medical and Chirurgical Faculty who testified that in his twenty years experience as counsel for this group he had not been faced with any problems about privilege.

[26] 4 MD. CODE (1957) Art. 35, § 13. As in the current situation there were no pending cases or any very recent decisions but when this "legislative oversight" was recognized it was corrected immediately.

through the years psychiatry has become more "secret" and the law more "open".[27]

The late Professor Wigmore, a leading authority on evidence, was a vigorous opponent of the physician-patient privilege. He established criteria to be met before a particular relationship became privileged. Elyce Zenoff, a former American Medical Association attorney, in a recent article sets up an analysis of Professor Wigmore's position, differentiating it in reason from another law professor's analysis of the psychiatrist-patient privilege.[28]

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[27] Note, *Tactical Use and Abuse of Depositions Under the Federal Rules*, 59 Yale L.J. 117, 136 (1949). "The virtually unrestricted examination under Rule 26 permits malicious, as well as over-extended, questioning. The abuse can take various forms. It can consist of a long series of annoying questions used to harry the deponent. It can involve a probing into personal matters possessing a blackmail value."

[28] "The analysis presented here of the physician-patient privilege and the priest-penitent relationship is that of Dean Wigmore, and the analysis of the psychotherapist-patient privilege is that discussed by Professor Slovenko in a recent article [6 Wayne L. Rev. 175 (1960)]. . . .

Wigmore Criteria

1. The communication must originate in a confidence that it will not be disclosed.
2. Confidentiality must be essential to the satisfactory maintenance of the relationship.
3. The relationship must be one which the community believes should be fostered.
4. The injury to the relationship from disclosure of the communication must be greater than the benefit gained for the correct disposition of the litigation.

Physician-Patient

1. There is little in the way of physical symptoms and conditions that a patient attempts to keep confidential.
2. Communication would be made even if it were not privileged.
3. The physician-patient relationship is one that should be fostered.
4. The harm done to the cause of justice through the suppression of truth is infinitely greater than the harm that would be done to the relationship.

Priest-Penitent

1. Permanent secrecy is essential to any religious confessional system.
2. Many confessions would not be made if there were a chance that they might later be disclosed in a court of law.
3. The priest-penitent relationship is one that should be fostered.
4. To destroy the confessional would be to weaken the backbone of many religions while the gain to justice could be slight.

Professor Slovenko's Analysis of the Psychotherapist-Patient Relationship.

1. Communications of this type are essentially of a confidential and secret nature.
2. They are less likely to be made and far more difficult to obtain if the patient knows that they may be revealed during the course of some future law suit.
3. The psychotherapist-patient relationship is one which should be fostered.
4. This type of information if revealed would produce far fewer benefits to justice than it would injury to the entire field of

Dr. Manfred Guttmacher, an esteemed psychiatrist, who has devoted his professional career to better understanding between psychiatry and the law, has been very interested in the problem of privilege. He has written extensively on this, both in his classical book "Psychiatry and the Law"[29] with Professor Weihofen, and alone in his Isaac Ray Lectures.[30] In the former he wrote:

> "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 is extremely hard for them to bring themselves to the point where they are willing to expose the dark recesses of their mind to the psychiatrist; often patients have undergone therapy for a year or more before they begin to reveal anything significant. 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."[31]

Limitations of time and space prevent me from going further. However, I do hope that I have been able to give the reader some idea as to the thoughts of the psychiatric community on this issue. There is no doubt in our minds that such legislation will reassure the continued security necessary for successful psychiatric treatment without causing any disservice to the law or society.

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psychotherapy." Zenoff, *Confidential and Privileged Communications*, 182 A.M.A.J. 656, 661 (Nov. 10, 1962). There is some question that Professor Wigmore never really looked upon the psychiatrist as being different from the general physician.

[29] Guttmacher and Weihofen, *Psychiatry and the Law* (Norton, 1952). See Ch. 12 — "The Patient's Privilege of Silence."

[30] Guttmacher, *The Mind of the Murderer* (Farrar, Straus and Cudahy, 1960). See Part III — "The Patient's Right to Secrecy."

[31] Guttmacher, *op. cit. supra*, n. 29, 272.