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## BEHIND CLOSED DOORS: LIMITATIONS ON PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE\*

DANIEL W. SHUMAN\*\*

THE MAJORITY OF the rules of evidence that bear upon psychiatric and psychological evidence concern its probative value.<sup>1</sup> For example, when a psychiatrist is required to describe her mental status examination of a patient or when a psychologist is asked to explain the validity of certain psychological tests he administered as a condition of their admissibility, the primary concern is whether this evidence meets a minimum threshold of probative value. Is a mental status examination an accurate vehicle to gauge the mental capacity of a patient and was it administered in a manner likely to maximize its accuracy? Is a particular psychological test a valid diagnostic technique and was it properly administered? A negative answer to these questions reflects on the probative value of the potential evidence. One set of evidence rules, however, closes the door on psychiatric and psychological evidence for reasons unrelated to its probative value. Rules of relational privilege are concerned with preserving the sanctity of a relationship notwithstanding the probative

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<sup>1</sup> The rules governing relevance and its limits, experts, hearsay and authentication all have as their core concern the probative value of evidence.

value of the evidence that might be obtained from the relationship.

The professions themselves have adopted codes which address these same concerns and describe the circumstances under which members of the profession should keep professional secrets and circumstances which may justify disclosure.<sup>2</sup> These codes describe the professional's duty of confidentiality and limit gratuitous disclosures of patient communications to a narrowly described set of circumstances that involve a risk to the patient or the public.<sup>3</sup> The codes may have legal significance in actions for professional discipline<sup>4</sup> or breach of privacy following an unjustified disclosure of confidential information by a psychiatrist or psychologist.<sup>5</sup> But these codes do not purport to govern, and arguably as privately imposed professional norms, could not govern, judicially compelled disclosure. That is the province of the rules of evidence and related constitutional considerations grouped under the head of privilege.

Medical privileges are, in the first instance, largely a matter of statutory law because the common law did not recognize a physician-patient privilege.<sup>6</sup> Thus any privilege applicable to psychiatrists or psychologists will, with limited exception,<sup>7</sup> be a legislative creation. These legislative creations have a common pattern; they describe the prerequisites for recognition of a privilege, the consequences of its recognition, and exceptions to the privilege.

Because psychiatrists as physicians are included within physician-patient privilege statutes, in those jurisdictions

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<sup>2</sup> *The Principles of Medical Ethics*, 246 J. A.M.A. 2187 (1981); *ETHICAL STANDARDS OF PSYCHOLOGISTS*, 36 AM. PSYCHOLOGY 633 (1981).

<sup>3</sup> "A physician shall respect the rights of patients, of colleagues and of the health professionals, and shall safeguard patient confidences within the constraints of the Law." *The Principles of Medical Ethics*, 246 J. A.M.A. 2187-88 (1981).

<sup>4</sup> See, e.g., CAL. BUS. & PROF. CODE § 2263 (West Supp. 1984).

<sup>5</sup> *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S.2d 668 (1977).

<sup>6</sup> *Whalen v. Roe*, 429 U.S. 589, 602 n.28 (1977); *Duchess of Kingston's Case*, 20 How ST. TRIALS 355, 573 (1776).

<sup>7</sup> *Allred v. State*, 554 P.2d 411 (Alaska 1976).

possessing no privilege statute exclusively applicable to psychiatrists, it is necessary to resort to the general physician-patient privilege. Many jurisdictions have adopted specialized psychiatrist, psychologist, and psychotherapist-patient privileges. These specialized privileges may exist in lieu of a general physician-patient privilege or in addition to it, but with different effect.

The traditional concept of practitioners of the healing arts and their relationship to litigation has changed substantially over the years. Physicians, psychiatrists and psychologists now play many roles in the litigation process. They may have a therapeutic relationship with a patient-litigant entered into prior to the onset of litigation which is now of consequence in the litigation. They may have a non-therapeutic relationship with the patient-litigant and see him only to assist in their testifying at trial. Or, they may not have a therapeutic relation with the patient, examine him, or testify at trial and instead function exclusively as the attorney's assistant in preparing the case.

The first situation, the therapeutic relationship, raises problems of medical privilege — physician, psychiatrist, psychologist, or psychotherapist-patient privilege. The latter two situations, both non-therapeutic, raise questions of privilege not of therapist and patient, but of the attorney and client and the attorney's assistants.

## I. THE PHYSICIAN-PATIENT PRIVILEGE

### A. *General Rule*

Although the common law did not recognize a physician-patient privilege, most state legislatures have now modified the common law in their states and enacted a physician-patient privilege.<sup>8</sup> The rationale for these privileges is that they permit the patient to disclose fully and truthfully his condition to his physician so that he may be

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<sup>8</sup> See Shuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C.L. REV. 893, 907 n.100 (1982) for a chart describing the pattern of medical privileges in the states.

effectively treated.<sup>9</sup> Notwithstanding the suggestions that these privileges actually play a negligible role in physician-patient relationships and frustrate factual inquiries in the trial process,<sup>10</sup> the number of physician-patient privileges has grown substantially over the years. The response to criticisms of these privileges has been, instead, to interpret the requirements for recognition of a privilege strictly and to find a waiver or exception rather liberally.<sup>11</sup>

The physician-patient privilege statutes from state to state share certain requirements for recognition of a privilege. There must be a patient, an individual who seeks out a physician for the purpose of obtaining medical treatment.<sup>12</sup> The person the patient seeks out for treatment must be a licensed physician or there must be a reasonable basis for the patient to assume that the individual is a physician who is licensed to practice medicine.<sup>13</sup> If it later appears that the individual sought out by the patient was not a physician or not currently licensed to practice medicine, the inquiry will focus on the reasonableness of the patient's belief that she had consulted a licensed physician. Thus, for example, contacting an individual listed under the physician listing in the phone book should give rise to a reasonable belief that the individual was a licensed physician.

Physician is generally defined to include allopathic and osteopathic physicians without reference to specialty, thus psychiatrists are included within the definition of physician. Generally not included within the statutory defini-

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<sup>9</sup> See, e.g., *State v. White*, 169 Conn. 223, 363 A.2d 143 (1975), *cert. denied*, 423 U.S. 1025 (1975); *Jones v. State*, 610 S.W.2d 535 (Tex. Civ. App. — Houston [1st Dist.] 1980, writ *ref'd n.r.e.*).

<sup>10</sup> Chafee, *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand*, 52 YALE L.J. 607 (1943); Ladd, *A Modern Code of Evidence*, 27 IOWA L. REV. 213 (1942).

<sup>11</sup> J. WEINSTEIN & M. BERGER, *WEINSTEIN'S EVIDENCE* § 504[01], at 504-09 (1982).

<sup>12</sup> *State v. Sweet*, 142 Vt. 238, 453 A.2d 1131 (1982); *State v. Jenkins*, 80 Wisc. 2d 426, 259 N.W.2d 109 (1977).

<sup>13</sup> See, e.g., ILL. REV. STAT. ch. 51, § 5.2 (1966).

tion of physician are other practitioners of the healing arts such as psychologists, dentists, nurses, chiropractors, or pharmacists.<sup>14</sup> Therefore, in the absence of a specialized privilege applicable to these practitioners or inclusion under an existing privilege,<sup>15</sup> no bar exists to compel judicial disclosure of their confidential communications with patients. There is a split of authority concerning whether interns not yet licensed to practice medicine qualify as physicians for the purposes of privilege.<sup>16</sup>

The communication between physician and patient sought to be protected by the privilege must be related to medical treatment and occur during the course of treatment.<sup>17</sup> Thus, for example, a discussion with one's physician about investment opportunities during an office visit or a gratuitous remark about one's condition after termination of the relationship would not qualify for protection under the privilege. Although some states limit the privilege's protection to oral communications or substitutes for oral communications such as pointing gestures, rather than all information learned from the patient including communications and the physician's observations of matters the patient may not intend to communicate, most states now cloak both under the privilege.<sup>18</sup>

The communications between physician and patient sought to be protected must have been intended by the patient to be confidential. It is not necessary for the communication to have taken place in the physician's office to conclude that it was intended to be confidential and the fact that the communication occurred in the physician's office is not a guarantee that it will be found to have been confidential. A communication in a private setting outside the physician's office suggests that confidentiality

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<sup>14</sup> C. McCORMICK, *McCORMICK ON EVIDENCE* § 99, at 246 n.1 (3d ed. 1984).

<sup>15</sup> See *infra* notes 51-74 and accompanying text.

<sup>16</sup> Compare *Erieka-Maryland Assurance Co. v. Gray*, 121 F.2d 104 (D.C. Cir. 1941) (intern included) with *Frederick v. Federal Life Ins. Co.*, 13 Cal. App. 2d 585, 57 P.2d 235 (Cal. 1935) (intern excluded).

<sup>17</sup> *San Francisco v. Super. Ct.*, 37 Cal. 2d 227, 231 P.2d 26 (1951).

<sup>18</sup> D. LOISELL & C. MUELLER, *FEDERAL EVIDENCE* § 215, at 599 (1978).

was intended while a communication in the physician's waiting room in the presence and hearing of other patients does not suggest that confidentiality was intended.

The presence of someone other than the physician and patient during the communication was, at one time, generally thought to be inconsistent with confidentiality. Presently, a more functional approach is usually used in inquiring about the necessity for the third party's presence. For example, the presence of a parent during the examination of a child,<sup>19</sup> or a nurse who is needed to assist the physician should not destroy confidentiality.<sup>20</sup>

Inclusion of privileged information within a medical record does not result in a loss of its privileged status.<sup>21</sup> Although many people have access to this information, the courts have assumed that this recording is a practical necessity. Additionally, everyone with access to medical records is part of the treatment team who has a medical need for this information.

The consequence of the recognition of a physician-patient privilege is that the patient may refuse to permit the physician's testimony about confidential communications between them. The physician is not rendered incompetent as a witness generally and thus, even in the absence of an exception or waiver, she may testify to non-privileged perceptions such as discussions with the patient before the onset of the physician-patient relationship or after its termination and non-therapeutic or non-confidential communications during the relationship. Most jurisdictions do not regard the existence of the physician-patient relationship itself as privileged; thus, the physician may be asked whether and when someone was a patient.<sup>22</sup>

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<sup>19</sup> *Grosslight v. Super. Ct.*, 72 Cal. App. 2d 501, 140 Cal. Rptr. 228 (1977).

<sup>20</sup> *State v. Scott*, 491 S.W.2d 514 (Mo. 1973); *Ostrawski v. Mockridge*, 242 Minn. 265, 65 N.W.2d 185 (1954).

<sup>21</sup> *Rudnick v. Super. Ct.*, 11 Cal. 3d 924, 523 P.2d 643, 114 Cal. Rptr. 603 (1974).

<sup>22</sup> *In re Zuniga*, 714 F.2d 632, 640 (6th Cir. 1983), *cert. denied*, 104 S.Ct. 426 (1983). *But see Ex parte Abell*, 613 S.W.2d 255 (Tex. 1981).

### B. *Waiver of the Privilege*

Because the physician-patient privilege is not a rule rendering the physician incompetent as a witness, but a right of the patient to prevent the physician from testifying as to certain confidential communications, it may be waived. However, unless waived or excepted, its effect on the physician's testimony is generally held to continue beyond the termination of the physician-patient relationship and even after the death of the patient.<sup>23</sup> When the physician's testimony is sought and the patient is not present, it should be assumed, in the absence of clear evidence to the contrary, that the patient did not wish the privilege waived.<sup>24</sup>

A waiver of the privilege by the patient may be express or implied. An express waiver could occur in court, for example, when the patient notifies the court that he wishes to waive the privilege, or out of court in an application for health insurance.<sup>25</sup> As with other waivers of rights, so long as it is knowing, intelligent, and voluntary, the waiver will be effective.<sup>26</sup> Conversely, evidence that the patient did not understand the waiver language in an insurance application because it was written in "legalese," or failed to comprehend the significance of submitting a death certificate to an insurance company in support of a claim for life insurance benefits when no other method of substantiating a claim exists<sup>27</sup> will defeat the waiver.

When a patient acts in a manner inconsistent with an intention to maintain the confidentiality of communications, a waiver of the privilege will be implied. This will occur when the patient publicly discloses the communica-

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<sup>23</sup> C. MCCORMICK, *supra* note 14, § 102, at 253.

<sup>24</sup> *In re Grand Jury Investigation of Onondaga Co.*, 59 N.Y.2d 130, 450 N.E.2d 678, 463 N.Y.S.2d 758 (1983).

<sup>25</sup> *United States v. Radetsky*, 535 F.2d 556, 569 n.14 (10th Cir.), *cert. denied*, 429 U.S. 820 (1976); *Leach v. Millers Life Ins. Co.*, 400 F.2d 179, 182 (5th Cir. 1968).

<sup>26</sup> *In re Pebsworth*, 704 F.2d 261, 262 (7th Cir. 1983); *Gaynier v. Johnson*, 673 S.W.2d 899, 905 (Tex. App. — Dallas 1984, no writ).

<sup>27</sup> *Kelly v. Allegan County Circuit Judge*, 382 Mich. 425, 169 N.W.2d 916 (1969).



tion with his physician in testimony or elsewhere,<sup>28</sup> or calls the physician as a witness and examines him as to the communications.<sup>29</sup> In some jurisdictions, the filing of a lawsuit in which the issue is the condition for which the patient was treated by this physician<sup>30</sup> will effect an implied waiver of the privilege.

Another implied waiver is addressed by Rule 35 of the Federal Rules of Civil Procedure.<sup>31</sup> Rule 35 permits the

<sup>28</sup> *Id.*

<sup>29</sup> *People v. Smith*, 59 N.Y.2d 156, 451 N.E.2d 157, 464 N.Y.S.2d 399 (1983); *State v. Carter*, 641 S.W.2d 54 (Mo. 1982).

<sup>30</sup> *See, e.g., San Francisco v. Super. Ct.*, 37 Cal. 2d 227, 231 P.2d 26 (1951); *Tex. R. EVID.* 510 (d)(5).

<sup>31</sup> *FED R. CIV. P.* 35. The full text of the rule provides:

**PHYSICAL AND MENTAL EXAMINATION OF PERSONS**

(a) Order for examination. When the mental or physical condition (including the blood group) of a party, or of a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control. The order may be made only on motion for good cause shown and upon notice to the person to be examined and to all parties and shall specify the time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made.

**(b) Report of Examining Physician**

(1) If requested by the party against whom an order is made under Rule 35(a) or the person examined, the party causing the examination to be made shall deliver to him a copy of a detailed written report of the examining physician setting out his findings, including results of all tests made, diagnoses and conclusions, together with like reports of all earlier examinations of the same condition. After delivery the party causing the examination shall be entitled upon request to receive from the party against whom the order is made a like report of any examination, previously or thereafter made, of the same condition, unless, in the case of a report of examination of a person not a party, the party shows that he is unable to obtain it. The court on motion may make an order against a party requiring delivery of a report on such terms as are just, and if a physician fails or refuses to make a report the court may exclude his testimony if offered at the trial.

(2) By requesting and obtaining a report of the examination so ordered or by taking the deposition of the examiner, the party examined waives any privilege he may have in that action or any other involving the same controversy, regarding the testimony of every other person who has examined or may thereafter examine him in respect of the same mental or physical condition.

(3) This subdivision applies to examinations made by agreement

court to order a mental or physical examination of a party or a person in the custody or legal control of a party when that person's mental or physical condition is in controversy, and good cause for the examination exists.<sup>32</sup> The person examined may request a copy of the report of the examination, but the request "waives any privilege he may have in that action or other involving the same controversy, regarding the testimony of every other person who has examined or may thereafter examine him in respect of the same mental or physical condition."<sup>33</sup> Thus, even if the filing of the action does not constitute an implied waiver of the privilege, a waiver will occur if the patient requests copies of the report from a court ordered examination.

Another question which arises with regard to both implied and express waivers is the effect of the waiver beyond the communication with the physician. Those courts that find a waiver without much difficulty also oftentimes give a broad effect to the waiver. These courts not only permit inquiry into all other relevant communications between the patient and the physician which is not testified about on direct examination, but also all relevant communications with other physicians. Conversely, those same courts which are reluctant to find a waiver will limit the effect of a waiver to a particular physician when an implied waiver results from calling the physician as a witness.<sup>34</sup> Likewise, these courts will construe narrowly these conditions or treatments they will find related to the present condition when an implied waiver results from instituting litigation related to that condition.<sup>35</sup>

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of the parties, unless the agreement expressly provides otherwise. This subdivision does not preclude discovery of a report of an examining physician or the taking of a deposition of the physician in accordance with the provisions of any other rule.

*Id.*

<sup>32</sup> *See id.*

<sup>33</sup> *Id.* § (b)(2).

<sup>34</sup> *State v. Olsen*, 271 Or. 369, 532 P.2d 230 (1975); *Gaynier v. Johnson*, 673 S.W.2d 899, 905 (Tex. App.—Dallas 1984, no writ).

<sup>35</sup> *Roberts v. Super. Ct.*, 9 Cal. 3d 330, 508 P.2d 309, 107 Cal. Rptr. 309 (1973);

C. *Exceptions to the Privilege*

There are certain categories of physician-patient relationships, which, because of their purpose, do not satisfy the requirements of the physician-patient privilege. This category includes court-ordered examinations,<sup>36</sup> employment examinations by an employer's physician,<sup>37</sup> and insurance examinations by an insurer's physician.<sup>38</sup> In these instances the purpose of the relationship is not treatment, thus the privilege's concern with full disclosure for effective treatment is not served and disclosure to a third person, a court, an employer, or an insurer is necessary to satisfy the purpose of the relationship. Although these relationships are not privileged, the physician may nevertheless be legally<sup>39</sup> or ethically<sup>40</sup> bound to explain the purpose of the examination and its non-privileged nature to the patient prior to commencing the examination.

The physician-patient privilege is the result of balancing the sanctity of a physician-patient relationship against the importance of obtaining the information it may cloak. Nevertheless, this balancing does not yield universally accepted conclusions, but rather conclusions varying in form from state to state. As a result, in many states the physician-patient privilege is inapplicable in certain categories of cases. Not all states, however, except the privilege's applications in all categories; some recognize very few exceptions while others recognize many. All states, however, recognize some exceptions. The categories of cases in which the physician-patient privilege may not ap-

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State *ex rel* Floyd v. Court of Common Pleas, 55 Ohio St. 2d 27, 377 N.E.2d 794 (1978).

<sup>36</sup> See, e.g., State v. Goquette, 67 Nev. 505, 221 P.2d 404 (1950); Jones v. State, 610 S.W.2d 535 (Tex. Civ. App. — Houston [1st Dist.] 1980, writ ref'd n.r.e.).

<sup>37</sup> McCormick v. Caterpillar Tractor Co., 85 Ill. 2d 352, 423 N.E.2d 876 (1981).

<sup>38</sup> Grey v. Los Angeles Superior Court, 62 Cal. App. 3d 698, 133 Cal. Rptr. 318 (1976).

<sup>39</sup> Estelle v. Smith, 451 U.S. 454 (1981); Salas v. State, 592 S.W.2d 653 (Tex. Civ. App. — Austin 1979, no writ).

<sup>40</sup> S. HALLECK, PSYCHIATRY AND THE DILEMMAS OF CRIME 329 (1967); *Report of the Task Force on the Role of Psychology in the Criminal Justice System*, 33 AM. PSYCHOLOGIST 1099, 1102 (1978).

ply include criminal,<sup>41</sup> civil commitment,<sup>42</sup> workers' compensation,<sup>43</sup> will contests,<sup>44</sup> and child abuse<sup>45</sup> or custody.<sup>46</sup>

Similarly, there are certain activities thought sufficiently injurious to public health and safety to require that application of the privilege be excepted and reporting to an appropriate public official required. Included in this category are instances of venereal disease,<sup>47</sup> gunshot wounds,<sup>48</sup> and fetal death.<sup>49</sup> In other jurisdictions, in addition to these specified exceptions, the trial judge is granted broad authority not to apply the privilege when it would not serve the interests of justice.<sup>50</sup> This type of provision permits the trial court to recognize and balance exceptions based upon the exigencies of a particular case.

## II. THE PYSCHIATRIST, PSYCHOLOGIST, AND PSYCHOTHERAPIST-PATIENT PRIVILEGES

Although the physician-patient privilege has been much criticized as being an insignificant factor in physician-patient relationships in which physical problems are the subject of treatment and a significant factor in the exclusion of probative evidence at trial,<sup>51</sup> this same criticism has not generally been applied to the treatment of mental or emo-

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<sup>41</sup> *People v. Arcega*, 32 Cal. 3d 504, 651 P.2d 336, 185 Cal. Rptr. 94 (1982); *State v. Soner*, 177 N.J. Super. 47, 424 A.2d 1182 (1980).

<sup>42</sup> *In re Alvarez*, 342 So. 2d 492 (Fla. 1977).

<sup>43</sup> *McCormick v. Caterpillar Tractor Co.*, 85 Ill. 2d 352, 423 N.E.2d 876 (1981); *State ex rel Holman v. Dayton Press*, 11 Ohio App. 3d 27, 462 N.E.2d 1243 (1984).

<sup>44</sup> *Gaynier v. Johnson*, 673 S.W.2d 899 (Tex. App. — Dallas 1984, no writ).

<sup>45</sup> *People v. Stritzinger*, 34 Cal. 3d 505, 668 P.2d 738, 194 Cal. Rptr. 43 (1983); *In re Courtney S.*, 130 Cal. App. 3d 567, 181 Cal Rptr. 843 (1982); N.C. GEN. STAT. § 8-53.1 (1981).

<sup>46</sup> *People v. Florendo*, 95 Ill. 2d 155, 447 N.E.2d 282 (1983); *Perry v. Fiumano*, 61 A.D.2d 512, 403 N.Y.S.2d 57 (N.Y. App. Div. 1978).

<sup>47</sup> *State v. Efrid*, 309 N.C. 802, 309 S.E.2d 228 (1983).

<sup>48</sup> *In re Grand Jury Investigation of Onondaga Co.*, 59 N.Y.2d 130, 450 N.E.2d 678, 463 N.Y.S.2d 758 (1983).

<sup>49</sup> *Schwiman v. New York City Health and Hosp. Corp.*, 44 A.D.2d 482, 355 N.Y.S.2d 781 (N.Y. App. Div. 1974).

<sup>50</sup> *E.g.*, N.C. GEN. STAT. § 8-53 (1981).

<sup>51</sup> *See supra* note 10 and accompanying text.

tional problems.<sup>52</sup> Because of the inherently sensitive and embarrassing nature of mental and emotional problems and the information that must be disclosed if treatment is to be effective, it is thought that a privilege is particularly appropriate for treatment of these types of problems. This reasoning has led to the adoption of specialized psychiatrist, psychologist and psychotherapist-patient privileges. The Federal Rules of Evidence, for example, originally did not contain a physician-patient privilege, but did contain a psychotherapist-patient privilege.<sup>53</sup>

These specialized privilege statutes generally follow the same pattern as the physician-patient privilege statutes, but substitute a different sort of therapist who must be seen to trigger the privilege. Psychiatrist-patient privileges apply to care rendered by a psychiatrist. Non-psychiatric physicians frequently provide counseling for the mental and emotional aspects of their patients' problems.<sup>54</sup> This care, however, is not included within the scope of the specialized psychiatrist-patient privilege.<sup>55</sup> Only when the physician is a psychiatrist or devotes a substantial portion of her practice to psychiatry will this privilege apply. Although some states, for example California, recognize a psychiatrist-patient privilege in addition to a physician-patient privilege,<sup>56</sup> most states which recognize a psychiatrist-patient privilege do not recognize a general physician-patient privilege.<sup>57</sup>

Psychologist-patient privilege statutes, unlike psychiatrist-patient privilege statutes, do not overlap with physician-patient privilege statutes. Psychologist-patient

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<sup>52</sup> Guttmacher & Weihofen, *Privileged Communications Between Psychiatrist and Patient*, 28 IND. L.J. 32 (1952); Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175 (1960).

<sup>53</sup> FED. R. EVID. 504, 56 F.R.D. 183, 242 (Proposed Rule 1973).

<sup>54</sup> Orleans, *How Primary Care Physicians Treat Psychiatric Disorders: A National Survey of Family Practitioners*, 142 AM. J. PSYCHIATRY 52 (1985).

<sup>55</sup> See, e.g., ALA. CODE § 34-26-2 (Supp. 1984); CONN. GEN. STAT. § 52-146d (1983).

<sup>56</sup> CAL. EVID. CODE §§ 990-1007, 1010-26 (West 1966 & Supp. 1984).

<sup>57</sup> See, e.g., CONN. GEN. STAT. § 52-146c (1983); FLA. STAT. ANN. § 90.503 (West 1979); MD. CTS. & JUD. PROC. CODE ANN. § 9-109 (1984).

privilege statutes exist in states that do not recognize a physician-patient privilege<sup>58</sup> and also exist in many states that do recognize a physician-patient privilege.<sup>59</sup> The psychologist-patient privileges require the patient to consult a licensed psychologist for treatment of a mental or emotional problem. Sometimes explicit,<sup>60</sup> but other times implicit, is the requirement that the psychologist be a clinical psychologist rather than an industrial or educational psychologist.<sup>61</sup>

Psychotherapist-patient privileges generally combine the psychiatrist and psychologist-patient privileges, however they are, in some instances, broader. While specialized psychiatrist-patient privileges include only treatment by a psychiatric physician, psychotherapist-patient privileges may include the treatment of a mental or emotional problem by a non-psychiatric physician.<sup>62</sup>

One question raised by the psychotherapist-patient privilege is whether non-psychiatric or psychological therapists should be included.<sup>63</sup> The psychotherapist-patient privilege potentially could include marriage counselors, drug and alcohol counselors, psychiatric social workers and various lay therapists. A more broadly drawn provision could also include friends and relatives who provide sage advice or soft shoulders.<sup>64</sup> Most psychotherapist-patient privileges do not include a non-physician or psychol-

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<sup>58</sup> ALA. CODE § 34-26-2 (Supp. 1984); CONN. GEN. STAT. § 52-146 (c) (1983).

<sup>59</sup> ILL. ANN. STAT. ch. 111, § 5306 (Smith-Hurd 1978 & Supp. 1984-85); MO. ANN. STAT. § 337.055 (Vernon Supp. 1984).

<sup>60</sup> CONN. GEN. STAT. § 52-146c(a) (1983).

<sup>61</sup> See D. LOUISELL & C. MUELLER, *FEDERAL EVIDENCE* § 216, at 607 (1978).

<sup>62</sup> FED. R. EVID. 504, 56 F.R.D. 180, 242 (Proposed Rule 1973); FLA. STAT. ANN. § 90.503 (West 1979); N.M. STAT. ANN., N.M.R. EVID. 504 (Judicial Pamphlet 10 1978).

<sup>63</sup> Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CAL. L. REV. 1050 (1973); Note, *The Social Worker-Client Relationship and Privileged Communications*, 1965 WASH. U.L.Q. 362.

<sup>64</sup> Krattemaker, *Testimonial Privileges in Federal Court: An Alternative to the Proposed Federal Rules of Evidence*, 62 GEO. L. J. 61 (1973).

ogist-patient privilege<sup>65</sup> or include special privileges for these other therapists.<sup>66</sup>

The pattern of requirements for recognition of a psychiatrist, psychologist, or psychotherapist-patient privilege is the same as for the physician-patient privilege. Someone seeking treatment must consult the appropriate type of therapist and communicate with them in confidential fashion on a topic necessarily related to treatment. Similarly, the same pattern of waiver and exclusion exceptions exists. There are certain problems, however, which are unique to these privileges.

As noted above, the identity of the patient is not generally protected from disclosure under the physician-patient privilege.<sup>67</sup> Because being identified as the patient of a psychiatrist or psychologist is thought to be a source of embarrassment and stigma,<sup>68</sup> it is argued that these privileges should cloak the identity of the patient as well as the substance of the communications.<sup>69</sup> Most jurisdictions have not accepted this argument.<sup>70</sup>

Group therapy, one form of treatment used by some psychiatrists, psychologists and other psychotherapists,<sup>71</sup> presents another unique problem. Because the presence of someone other than the therapist and the patient is thought to imply an absence of confidentiality, most privilege statutes do not protect communications during group therapy sessions. Based upon the argument that group therapy is an effective and comparatively inexpensive form of therapy in which patients become each others' therapists, it has been argued that group therapy

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<sup>65</sup> *But see*, NEV. REV. STAT. § 49.215.2 (1979) (includes psychiatric social worker in definition of doctor).

<sup>66</sup> MICH. COMP. LAWS ANN. § 338.1043 (West 1976) (marriage counselors); N.Y.C. Pub. L. 12, § 4508 (social workers).

<sup>67</sup> *See supra* note 22 and accompanying text.

<sup>68</sup> *See* Shuman & Weiner, *supra* note 8.

<sup>69</sup> J. WEINSTEIN & M. BURGER, *supra* note 11 § 504[04], at 504-23.

<sup>70</sup> *But see Ex parte* Abell, 613 S.W.2d 255 (Tex. 1981).

<sup>71</sup> L. KOVEL, A COMPLETE GUIDE TO THERAPY 162 (1976).

should be included within these privileges.<sup>72</sup> Acceptance of this argument is limited,<sup>73</sup> perhaps because even if the privilege applies to the psychiatrist's or psychologist's testimony, the mouths of the other patients are not necessarily shut.

#### IV. THE ATTORNEY-CLIENT PRIVILEGE AND THE WORK-PRODUCT RULE

Physician, psychiatrist, psychologist and psychotherapist-patient privileges apply only when the relationship has, at least as one of its purposes, treatment of the patient or diagnosis in contemplation of treatment. Thus, when the purpose of the relationship is not at all treatment, but preparation for expert testimony or assistance in preparation of the case, an attempt to cloak these communications under the physician, psychiatrist, psychologist, or psychotherapist-patient privilege will not be successful. Viewing these communications from the perspective of the attorney-client relationship and the privilege accorded it, however, may yield a different result.

##### A. *Civil Proceedings*

The attorney-client privilege, which was recognized at common law, has traditionally been thought to apply to confidential communications between attorney and client on the subject of legal services. Communications between the attorney and the attorney's assistant or potential witness have not been included within the traditional contemplation of this privilege, yet, have nonetheless been found deserving of protection. The work product doctrine, which received recognition in the United States Supreme Court's decision in *Hickman v. Taylor*<sup>74</sup> and is amplified by rules of procedure incorporating this concept,<sup>75</sup>

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<sup>72</sup> Cross, *Privileged Communications Between Participants and Group Psychotherapy*, 1970 L. & Soc. ORDER 191.

<sup>73</sup> *State v. Andring*, 342 N.W.2d 128 (Minn. 1984).

<sup>74</sup> 329 U.S. 497 (1947).

<sup>75</sup> FED. R. CIV. P. 26(b) (3), (4).



has been an additional source of protection. *Hickman* limited discovery by the defendant of the written statements of prospective witnesses and memoranda of oral statements obtained by the plaintiff's attorney to a limited set of circumstances designed to prevent disclosure of the attorney's thought processes and to limit disclosure of written statements of witnesses to circumstances of necessity.<sup>76</sup>

One question not addressed in *Hickman v. Taylor* was the discovery of expert witnesses retained by an adverse party in preparation for trial. This question has now been addressed for civil actions in the federal courts by the 1970 amendment to Rule 26(b)(4) of the Federal Rules of Civil Procedure, which is more cautious in its approach than many state rules.<sup>77</sup> It states:

(4) Trial Preparation: Experts. Discovery of facts known and opinions held by experts, otherwise discoverable under the provisions of subdivision (b)(1) of this rule and acquired or developed in anticipation of litigation or for trial, may be obtained as follows:

(A) (i) A party may through interrogatories require any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. (ii) Upon motion, the court may order further discovery by other means, subject to such restrictions as to scope and such provisions, pursuant to subdivision (b)(4)(C) of this rule, concerning fees and expenses as the court may deem appropriate.

(B) A party may discover facts known or opinions held by an expert who has been retained or specially employed by another party in anticipation of litigation or preparation for trial and who is not expected to be called as a witness at trial, only as provided in Rule 35(b) or upon a showing

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<sup>76</sup> 329 U.S. at 509-14.

<sup>77</sup> C. WRIGHT & A. MILLER, FEDERAL PRACTICE AND PROCEDURE § 2029, at 241 (1970).

of exceptional circumstances under which it is impracticable for the party seeking discovery to obtain facts or opinions on the same subject by other means.

(C) Unless manifest injustice would result, (i) the court shall require that the party seeking discovery pay the expert a reasonable fee for time spent in responding to discovery under subdivisions (b)(4)(ii) and (b)(4)(B) of this rule; and (ii) with respect to discovery obtained under subdivision (b)(4)(A)(ii) of this rule the court may require, and with respect to discovery obtained under subdivision (b)(4)(B) of this rule the court shall require, the party seeking discovery to pay the other party a fair portion of the fees and expenses reasonably incurred by the latter party in obtaining facts and opinions from the expert.<sup>78</sup>

This rule addresses the discovery of two categories of experts, those expected to be called as witness at trial and those utilized in case preparation and not expected to be called as a witness at trial.

Regarding those individuals whom the opposing party may call as a witness at trial, a chronology for discovery is prescribed. First, Rule 26(b)(4)(A)(i) permits a demand of the opposing party by interrogatory of the identity of each proposed expert expected to be called, the subject matter of the expert's testimony, and the substance of the facts and opinions as to which the expert will testify and a summary of the grounds for each opinion. Some courts have interpreted the identity requirement to include sufficient information to identify and locate this individual.<sup>79</sup> The duty to supplement responses of Rule 26(e) applies here, making insufficient the response at trial that it was decided to use this expert only after responding to the interrogatory.<sup>80</sup> Failure to list an expert in answer to this interrogatory may result in a restriction of the expert's testimony.<sup>81</sup>

Following the interrogatory stage of discovery, under

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<sup>78</sup> FED. R. CIV. P. 26(b)(4).

<sup>79</sup> *Mann v. Newport Tankers Corp.*, 96 F.R.D. 31 (S.D.N.Y. 1982).

<sup>80</sup> FED. R. CIV. P. 26(e).

<sup>81</sup> *Simonsen v. Barlo Plastics Co.*, 551 F.2d 469 (1st Cir. 1977).

26(b)(4)(ii) a party may move for further discovery of an expert, typically by deposition; however, the court may also order the production of documents.<sup>82</sup> The court's order permitting this additional discovery should contain a provision for reasonable compensation of the expert by the party seeking discovery and may restrict the scope or sequence.<sup>83</sup> However, no showing of substantial need or good cause for this subsequent state of discovery needs to be shown.<sup>84</sup>

Discovery under 26(b)(4)(B) of experts retained by an opponent, but not intended to be called at trial, is severely limited. An opposing party may, in most courts, discover the names and addresses of these experts,<sup>85</sup> but may discover relevant facts and opinions in the possession of these individuals only if this information is not reasonably available elsewhere or as provided in Rule 35(b).<sup>86</sup> This limitation applies to formal discovery only, thus to the extent that the expert retained by a party is willing to talk informally with the opposing party, the discovery rules have no application. If the expert is consulted but not retained or expected to be called as a witness, no disclosure of even the expert's identity need occur.<sup>87</sup>

Rule 35(b) of the Federal Rules of Civil Procedure involves a request for the report of a court ordered examination by the examined party, which triggers a corresponding obligation by the requesting party to turn over any reports of examinations made before or after for the same condition.<sup>88</sup> For example, even if the plaintiff

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<sup>82</sup> *In re IBM Peripheral EDP Devices Antitrust Litigation*, 77 F.R.D. 39 (N.D. Cal. 1977).

<sup>83</sup> FED. R. CIV. P. 26(b)(4)(C).

<sup>84</sup> *Herbst v. Int'l Tel. & Tel. Corp.*, 65 F.R.D. 528 (D. Conn. 1975); *United States v. John R. Piquette Corp.*, 52 F.R.D. 370 (E.D. Mich. 1971). *But see* *Wilson v. Resnick*, 51 F.R.D. 510 (E.D. Pa. 1970).

<sup>85</sup> *Baki v. B.F. Diamond Constr. Co.*, 71 F.R.D. 179 (D. Md. 1976). *But see* *Ager v. Jane C. Stormont Hosp. & Training School for Nurses*, 622 F.2d 496 (10th Cir. 1980).

<sup>86</sup> FED. R. CIV. P. 35(b).

<sup>87</sup> *Baki v. B.F. Diamond Const. Co.*, 71 F.R.D. 179, 182 (D. Md. 1976).

<sup>88</sup> FED. R. CIV. P. 35(b).

did not intend to call as a witness Dr. Gonzales, a psychologist who examined his client and prepared a report to help prepare for trial, if the plaintiff is examined under Rule 35 at the defendant's request by Dr. Schwartz, a psychiatrist, and the plaintiff requests and receives a copy of Dr. Schwartz's report, the plaintiff is obligated to deliver, upon request, a copy of Dr. Gonzales' report to the defendant. If Dr. Gonzales provides assistance to the plaintiff's attorney without conducting an examination of the plaintiff, by suggesting topics for cross examining the defendant's expert for example, the reciprocity provisions of 35(b) are not triggered.<sup>89</sup>

The other circumstance under which experts not intended to be called are discoverable is "upon a showing of exceptional circumstances under which it is impracticable for the party seeking discovery to obtain facts or opinions on the same subject by other means."<sup>90</sup> This provision applies to the situation in which expertise on the subject of the litigation is severely limited and one party has prevented the opponent from utilizing an expert by retaining him for trial preparation but not testimony. For example, in *Dixon v. Cappellini*,<sup>91</sup> an action against a deprogrammer by a "church" member, psychiatric and psychological reports of treatment received by the plaintiff shortly after the deprogramming were found to be unique and contain relevant information not otherwise obtainable by the defendants following institution of the lawsuit eight months later.<sup>92</sup> The court questioned inclusion of the reports as trial preparation materials, but explained the treatment which should be given these reports if governed by Rule 26(b)(4).<sup>93</sup>

Witnesses who may qualify as experts but whose knowledge was not gained in anticipation of the instant litiga-

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<sup>89</sup> *Nemetz v. Aye*, 63 F.R.D. 66 (W.D. Pa. 1974).

<sup>90</sup> FED. R. CIV. P. 26(b)(4)(B).

<sup>91</sup> 88 F.R.D. 1 (M.D. Pa. 1980).

<sup>92</sup> *Id.* at 3.

<sup>93</sup> *Id.*

tion are not addressed by Rule 26(b)(4).<sup>94</sup> For example, the defendant psychiatrist or psychologist in an action for malpractice may be sent interrogatories or subjected to depositions in the same manner as any other defendant.<sup>95</sup>

### B. *Criminal Proceedings*

Most courts recognize that communications between the defendant in a criminal proceeding and a psychiatrist or psychologist not treating the defendant but retained to assist in preparation for trial should be privileged, if at all, under the attorney-client privilege and not a medical privilege.<sup>96</sup> The extension of the attorney-client privilege in criminal cases to communications between a defendant and a psychiatrist or psychologist retained to assist in case preparation is governed largely by case law. Frequently these cases involve a psychiatrist or psychologist consulted by the defense on the viability of an insanity defense who renders an opinion unfavorable to the defendant which the prosecution discovers and seeks to introduce into evidence.

Most courts have little problem concluding that, in criminal cases, the attorney-client privilege extends to communications made to a psychiatrist or psychologist retained to assist in preparation of the case.<sup>97</sup> The difficulty arises in determining whether, by raising the insanity defense, the privilege is impliedly waived as to the non-testifying psychiatrist or psychologist who rendered the unfavorable opinion.

The majority of courts addressing this problem reject the notion that raising the insanity defense waives the attorney-client privilege as to the retained non-testifying expert.<sup>98</sup> The rationale for this approach is that implying

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<sup>94</sup> *Rodriguez v. Hrinda*, 56 F.R.D. 11 (W.D. Pa. 1972).

<sup>95</sup> *Keith v. Van Dorn Plastic Machinery Co.*, 86 F.R.D. 458 (E.D. Pa. 1980); *Rodriguez v. Hrinda*, 56 F.R.D. 11 (W.D. Pa. 1972).

<sup>96</sup> *United States v. Alvarez*, 519 F.2d 1036 (3d Cir. 1975).

<sup>97</sup> *Id.*; *People v. Lines*, 13 Cal. 3d 500, 531 P.2d 793, 119 Cal. Rptr. 225 (1975).

<sup>98</sup> *United States v. Alvarez*, 519 F.2d 1036 (3d Cir. 1975); *People v. Lines*, 13 Cal. 3d 500, 531 P.2d 793, 119 Cal. Rptr. 225 (1975); *People v. Hilliker*, 29 Mich.

waiver would chill the defendant's willingness to confide in these experts and thereby restrict the attorney's ability to prepare and investigate the case for trial. Thus, in the majority of American jurisdictions the defense may prevent compelled judicial disclosure of unfavorable pretrial psychiatric and psychological examinations prepared at the request of defense counsel.

The minority rule is that raising the insanity defense is inconsistent with the retention of confidentiality in all relevant psychiatrist or psychologist-patient communications whether sought to be cloaked by a medical privilege<sup>99</sup> or the attorney-client privilege<sup>100</sup> and results in a waiver of any applicable privilege. Under this rule a privilege generally applies until the insanity defense is raised, thus a decision not to raise this or related defenses prevents the prosecution from discovering pretrial psychiatric or psychological examinations prepared at the request of defense counsel. Of course, even under the majority rule once the defendant calls a psychiatrist or psychologist to the witness stand, regardless of the previous attorney-client or medical privilege, a waiver occurs as to communications with that psychiatrist or psychologist.<sup>101</sup>

#### V. CONSTITUTIONAL SUPPORT FOR THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

In the absence of statutory privilege protecting confidential communications between a psychiatrist or psychologist and patient, an argument may be advanced in favor of a constitutional right to privacy which cloaks confidential psychotherapist-patient communications. This argument relies on such Supreme Court decisions as *Roe*

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App. 543, 185 N.W.2d 831 (1971); *State v. Kociolek*, 23 N.J. 400, 129 A.2d 417 (1957).

<sup>99</sup> *People v. Al-Kanani*, 33 N.Y.2d 260, 307 N.E.2d 43, 351 N.Y.S.2d 969 (1973).

<sup>100</sup> *State v. Carter*, 641 S.W.2d 54 (Mo. 1982); *People v. Edny*, 39 N.Y.2d 620, 350 N.E.2d 400, 385 N.Y.S.2d 23 (1976).

<sup>101</sup> *Ballew v. State*, 640 S.W.2d 237 (Tex. Crim. App. 1982).

*v. Wade*<sup>102</sup> and *Griswold v. Connecticut*<sup>103</sup> to support the conclusion that a constitutional zone of privacy may be found relying upon various provisions in the Bill of Rights sufficient to protect against compelled disclosure of intimate personal details and to protect autonomy in personal decision making, specifically the decision to consult a psychotherapist.<sup>104</sup>

The Supreme Court has not yet clearly accepted or rejected this contention. In *Whalen v. Roe*,<sup>105</sup> a challenge to a New York computerized storage scheme for certain prescriptions, the Court concluded only that the New York scheme did not "on its face, pose a sufficiently grievous threat to either interest to establish a constitutional violation."<sup>106</sup> Whether this conclusion should be read to support an implicit recognition of a zone of privacy cloaking physician-patient relations generally has yet to be clarified. There are, however, a number of lower federal court and state court decisions before and after *Whalen* which address this issue.

The decisions can be grouped into three categories. The first category includes cases which reject the existence of a constitutional right of privacy in psychotherapist-patient relationships. The second category recognizes the existence of the right, but finds it should not apply in the instant case. The third category of cases recognizes the existence of the right and finds it should apply in the instant case.

The rejection of a constitutional right of privacy cloaking psychiatrist-patient relationships is illustrated by *Felber v. Foote*,<sup>107</sup> a challenge by a psychiatrist to a Connecticut statutory scheme requiring disclosure of the names and other information about drug dependent people to the state commissioner of health. The federal district court

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<sup>102</sup> 410 U.S. 113 (1973).

<sup>103</sup> 381 U.S. 479 (1965).

<sup>104</sup> *Lora v. Board of Education*, 74 F.R.D. 565, 570 (E.D.N.Y. 1977).

<sup>105</sup> 429 U.S. 589 (1977).

<sup>106</sup> *Id.* at 600.

<sup>107</sup> 321 F. Supp. 85 (D. Conn. 1970).

summarily rejected this challenge with the admonition that there is no general constitutional right of privacy and the specific recognitions of this right have not included the physician-patient relationship. It is significant that this case was decided before *Roe v. Wade*,<sup>108</sup> which extended the right of privacy to a particular physician-patient relationship, that of a pregnant woman and her physician, and also before *Whalen v. Roe*.<sup>109</sup>

The cases recognizing a constitutional right of privacy cloaking the psychotherapist-patient relationship are subsequent to *Roe v. Wade*, involve a patient who entered therapy prior to the litigation, and do not involve a plaintiff-patient. *In re B*,<sup>110</sup> for example, involved an attempt to compel disclosure regarding treatment of a juvenile's mother some years earlier, in the dispositional phase of a delinquency proceeding. Relying on the state and federal constitutions, the Supreme Court of Pennsylvania concluded that a right of privacy existed cloaking these past treatments, but the same protection would not apply to current voluntary evaluation by a court appointed psychiatrist.<sup>111</sup>

*Hawaii Psychiatric Society v. Anyoshu*<sup>112</sup> involved an attempt to enjoin an investigation of fraud in the Hawaii medicaid program which entailed a search of the records of a clinical psychologist. The district court held that a constitutional right of privacy cloaks the psychotherapist-patient relationship and in the absence of a compelling state interest judicially compelled disclosure should not occur.<sup>113</sup> Because nothing had yet suggested that this psychologist had engaged in fraud or that a search of this sort of records was necessary to prevent fraud on a programmatic level, the court enjoined the record search.

In the next category of cases the court recognized the

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<sup>108</sup> 410 U.S. 113 (1973).

<sup>109</sup> 429 U.S. 589 (1977).

<sup>110</sup> 394 A.2d 419 (Pa. 1978).

<sup>111</sup> *Id.* at 426.

<sup>112</sup> 481 F. Supp. 1028 (D. Hawaii 1979).

<sup>113</sup> *Id.* at 1039.



existence of a right of privacy, but concluded that its protections had been waived by the patient or a compelling state interest in favor of disclosure existed. *In re Lifshultz*<sup>114</sup> involved a patient who initiated a personal injury action and who received psychiatric care ten years earlier. The Supreme Court of California recognized the existence of a right of privacy for psychotherapist-patient relationships, but found that this protection was waived by the patient as to those conditions disclosed in bringing the action.<sup>115</sup>

Another illustration of this position is found in *Lora v. Board of Education of the City of New York*,<sup>116</sup> a suit challenging the placement of emotionally handicapped children. There the plaintiffs sought to have their experts inspect randomly selected student diagnostic and referral files without student names or identifying information. In response to the school board's assertion of these students' right to privacy, the court recognized the existence of the right, but found that the need for the information in the litigation to protect the interests of this class of students and the protection against disclosure of the identity of individual students, justified limited disclosure.<sup>117</sup>

## VI. FEDERAL PROGRAM LIMITATIONS

The federal government provides services and funding for a number of programs designed to treat mental or emotional disorders. Specific limitations on the disclosure of confidences made within treatment programs operated or funded by the federal government apply to drug<sup>118</sup> and alcohol treatment programs.<sup>119</sup> These limita-

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<sup>114</sup> 2 Cal. 3d 478, 467 P.2d 557, 85 Cal. Rptr. 829 (1970). See also *Ceaser v. Mountanos*, 542 F.2d 1064 (9th Cir. 1976) (denying protection of psychotherapist-patient privilege to communication relevant to issues concerning mental or emotional condition of patient if such was put in issue by the patient).

<sup>115</sup> *In re Lifshultz*, 85 Cal. Rptr. 829, 838-39, 467 P.2d 557, 567 (1970).

<sup>116</sup> 74 F.R.D. 565 (E.D.N.Y. 1977).

<sup>117</sup> *Id.* at 574.

<sup>118</sup> 42 U.S.C. § 290dd-3 (Supp. 1984).

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

tions, although set forth in separate sections, create identical limitations.<sup>120</sup>

Both sections operate much like a relational privilege to

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<sup>120</sup> 42 U.S.C. § 290dd-3 provides:

Confidentiality of patient records

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records con-

limit compelled judicial disclosure of records of a patient's identity, diagnosis, prognosis or treatment in a drug or alcohol program conducted, regulated or assisted by the federal government. Two exceptions apply in the context of judicial disclosure, written consent by the patient and a court order based upon a showing of good cause. The statute directs a court in gauging good cause to weigh the public interests in favor of disclosure against its consequence to this and other patients' treatment.

A number of decisions, particularly in the field of drug treatment, have addressed the court-ordered disclosure exception. Disclosure under this section should be extremely limited and where other sources of similar evidence exist, disclosure should not occur.<sup>121</sup> When no other similar evidence is available and the public interest in the outcome is substantial, as for example in child abuse or neglect cases, disclosure may be ordered.<sup>122</sup>

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cerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of records

The prohibitions of this section do not apply to any interchange of records —

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

*Id.*

<sup>121</sup> *United States v. Graham*, 548 F.2d 1302, 1314 (8th Cir. 1977).

<sup>122</sup> *In re Baby X*, 97 Mich. App. 111, 293 N.W.2d 736 (1980).

Frequently, this issue arises in prosecution for drug-related offenses when the government's case against a participant in the drug treatment program has been assisted by a co-patient.<sup>123</sup> Although regulations have been promulgated formally prohibiting the employment or enrollment of undercover agents in these programs,<sup>124</sup> the problem continues. The cases seek to draw fine distinctions by concluding that the informant was not there to ferret out drug offenses<sup>125</sup> or that the statute limits disclosure of records but not an informant's testimony not based upon these records.<sup>126</sup>

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<sup>123</sup> *United States v. Coffman*, 567 F.2d 960 (10th Cir. 1977); *Armenta v. Superior Court*, 61 Cal. App.3d 584, 132 Cal. Rptr. 586 (1976); *State v. Keleher*, 5 Kan. App. 2d 400, 617 P.2d 1265 (1980).

<sup>124</sup> 42 C.F.R. § 2.19 provides:

Undercover agents and informants — Rules.

(a) *Definitions*. As used in this section, § 2.19-1, and §§ 2.67 and 2.67-1, —

(1) The term "undercover agent" means a member of Federal, State, or local law enforcement or investigative agency whose identity as such is concealed from either the patients or personnel of a program in which he enrolls or attempts to enroll.

(2) The term "informant" means a person who, at the request of any Federal, State, or local law enforcement or investigative agency or officer, carries on observation of one or more persons enrolled in or employed by a program in which he is enrolled or employed, for the purpose of reporting to such agency or officer information concerning such persons which he obtains as a result of such observation subsequent to such request.

(b) *General prohibition*. Except as otherwise provided in paragraph (c) of this section, or as specifically authorized by a court order granted under § 2.67 —

(1) No undercover agent or informant may be employed by or enrolled in any alcohol or drug abuse treatment program;

(2) No supervisor or other person having authority over an undercover agent may knowingly permit such agent to be or remain employed by or enrolled in any such program; and

(3) No law enforcement or investigative officer may recruit or retain an informant with respect to such a program.

(c) *Exceptions*. The enrollment of a law enforcement officer in a treatment program shall not be deemed a violation of this section if (1) such enrollment is solely for the purpose of enabling the officer to obtain treatment for his own abuse of alcohol or drugs, and (2) his status as a law enforcement officer is known to the program director.

42 C.F.R. § 2.19 (1984).

<sup>125</sup> *United States v. Coffman*, 567 F.2d 960 (10th Cir. 1977).

<sup>126</sup> *State v. Keleher*, 5 Kan. App. 2d 400, 617 P.2d 1265 (1980); *State v. Bethea*,

## VII. CONCLUSION

Although evidence resulting from communications between psychiatrists or psychologists and their patients may be highly probative in a lawsuit, societal concerns with privacy have resulted in limits on judicial access to this evidence. Because the rationale for these limits and its pervasiveness varies from one context to the next, a maze of rules and exceptions limiting disclosures of psychiatrist or psychologist-patient communications has evolved. An attorney will not know from case to case whether he wishes these doors to be closed or open, and must learn both how they open and close.

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35 N.C. App. 512, 241 S.E.2d 869 (1978); *Armenta v. Superior Court*, 61 Cal. App. 3d 584, 132 Cal. Rptr. 586 (1976).