COMMENT

PRIVILEGED COMMUNICATIONS BETWEEN PHYSCHIATRIST AND PATIENT*

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and

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A doctor on the witness stand is in most jurisdictions not allowed, without his patient's consent, to disclose any information acquired in attending the patient in a professional capacity.[1] The leading authorities on the law of evidence rather unanimously take the view that this privilege serves no useful legal purpose, that on the contrary it does real harm in numerous cases by preventing the discovery of the truth, and that it should be abolished.[2] The Model Code of Evidence, prepared by a distinguished committee under the aegis of the American Law Institute, in its original draft made no provision for any such privilege, but lawyers from the states which recognize the privilege forced its inclusion, although with provisions limiting its application very drastically.

Whether the objections levelled against the privilege in the types of cases where abuse is most frequent—for example, personal injury cases—hold valid in psychiatric cases has never been adequately con-

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1. See 8 WIGMORE, EVIDENCE § 2380 (3rd ed. 1940); Note, 52 COL. L. REV. 383 (1952). Seventeen states retain the common law rule, under which no privilege is recognized covering communications between physician and patient. Chafee, *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?*, 52 YALE L.J. 607, 18 ANN. INT. MED. 606 (1943).

2. 8 WIGMORE, EVIDENCE §§ 2380-91; Chafee *supra* note 1; Curd, *Privileged Communications between the Doctor and his Patient—An anomaly of the Law*, 44 W. Va. L.Q. 165 (1938); Morgan, *Suggested Remedy for Obstructions to Expert Testimony by Rules of Evidence*, 10 U. CHI. L. REV. 285 (1943).

sidered. A few months ago, however, the issue was squarely raised by a Chicago psychiatrist, Dr. Roy R. Grinker, director of the Institute for Psychosomatic and Psychiatric Research and Training, at Michael Reese Hospital. He was summoned to testify in a suit for alienation of affections brought by a husband against another man. Dr. Grinker had treated the wife, and he refused to divulge in court confidential information, which might have been prejudicial to her, communicated to him by her while she was in the hospital.

Dr. Grinker was ready to be cited for contempt of court, if necessary, and take the issue to the appellate courts. The trial judge ruled, however, that a psychiatrist was not required to testify to matters told to him in confidence, even though there is no Illinois statute conferring such a privilege.[3]

We submit that the judge's basic premise is correct. The peculiarly close relationship of trust and confidence required between physician and patient in psychotherapy makes the situation a special one, not necessarily governed by the same considerations as the ordinary doctor-patient relationship.

It is not our purpose to quarrel with the basic viewpoint of the evidence authorities that the privilege, as applied to doctor-patient relations generally, is unsound. But most of the objections that have been raised against it are hardly applicable to psychiatric cases. Thus, it has been said that few patients have litigation in mind when they consult a doctor, or have any reason for wanting to keep the facts of their illness or injury secret. Of those who do have litigation in mind, the majority, such as the personal injury plaintiffs, are usually anxious to round up as many witnesses as possible to testify in open court as to what happened. If such a patient objects to the testimony of the doctor who examined or treated him, it is not because he wants

3. "The psychiatrist's sphere of interest," said Judge Harry M. Fisher, "necessarily covers every experience of the patient. He may be interested in knowing the experiences of childhood. That may weigh very heavily with him in determining the cause of the disturbance. He may be interested in the experience of the patient during puberty, during adolescence. In fact, what he seeks to do is to bring back to the conscious memory of the patient things forgotten but which lie dormant in the subconscious mind. He probes deeply, and it is necessary for him to get that information out of the mouth of his patient. . . . It doesn't require any scientific knowledge to understand that there can be no success in the effort to ascertain the true cause of the disturbance or in determining the kind of treatment that should be applied unless there is a complete confidence in the mind of the patient, not alone in the capacity and skill of the psychiatrist, but in the secrecy of the things transpiring in the doctor's chambers. That relationship in that respect is unique and is not at all similar to the relationship between physician and patient." This quotation was taken from Judge Fisher's opinion which was sent to Professor Weihofen by Dr. Grinker. Also see Chicago Sun-Times, June 25, 1952, § 1, p. 3, col. 3.

to keep his injuries secret, but almost certainly because he is afraid the doctor will testify that he was not injured at all! Mental ill health, however, is still a matter of which patients are likely to be more ashamed than physical ill health or injury, and there is a good deal more reason for supposing that a person who consults a phychiatrist intends to speak in more strict confidence than the automobile accident plaintiff. Of the types of cases in which the privilege is most often invoked, the chief one where psychiatric questions ordinarily arise is the will contest in which the testator's mental competency is disputed. Less frequently, psychiatric questions arise also in divorce cases where the patient may have confessed infidelities to his psychiatrist, and in cases of individuals seeking treatment for perverse sexual behavior. Unlike the personal injury plaintiff, the testator in a will contest is not voluntarily in court alleging that he was injured or ill. Of infidelities and sexual perversion, it is obvious that the patient is likely to have the possibility of litigation in mind, and probably would not be willing to speak frankly to his psychiatrist if he knew the latter could be compelled to testify.

The psychiatrist must insist on very personal data, and must explore the relationship of the patient's acts to his basic drives, which can only be adequately revealed by his deepest and most secret thoughts and feelings. This is true not only in psychoanalysis but in all psychotherapy. The possibly neurotic nature of even such patently criminal acts as forgery or theft cannot be determined without exploring the patient's attitudes and behavior in regard to masturbation, homosexuality, etc.

What is more, the patient's statements may reveal to his therapist much more than the patient intends or realizes. 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, phantasies, sins and 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.

The patient may begin treatment with a distrust of all persons who have played a prominent role in his life, and so without any basis for trust in the analyst or in anyone else. He cannot suddenly perform an act or assume an attitude that is beyond his experience. Only slowly and painfully can he be brought into a healthy relationship of security and trust with the psychiatrist, and achieve a feeling of being accepted for what he is without the attachment of moral judgments. This struggle goes on in large parts at an unconscious level. Unless the patient feels relaxed and safe with his therapist, powerful control is unconsciously exercised by the psychological mechanism of repression. When such a feeling of security is lacking, the patient unwittingly blocks or stultifies himself.

Perhaps all of the privileged relationships that the law protects are those in which the communicant becomes in a sense an extension of the personality of the communicator. Husband and wife, we say, are one; when the husband discusses a subject with his wife, he is talking to his other, or as we say, his better half. The client talking to his lawyer is talking to his own representative, his champion, his advocate, his "mouthpiece," to use a vulgar term which very aptly expresses this concept of the extension of the self. The priest, the "father," is the intermediary through whom one talks to God, to relieve oneself of the weight of sin-consciousness. The patient revealing his anxieties and his guilt feelings to the psychiatrist is also trying to work his way through to peace and understanding. The psychiatrist has become for him the loving and forgiving parent.

Of course, these considerations, emphasizing the usefulness and even the necessity of preserving the confidentiality of the psychiatrist-patient relationship, must be balanced against the importance of getting at the truth in litigated cases before we can reach a considered judgment as to whether the privilege should be allowed. Suppose in the trial of Alger Hiss that it had transpired that Whittaker Chambers, the one all-important witness against Hiss, had been under treatment by a psychiatrist (this is a wholly supposititious illustration, let it be understood, not intended to be taken as true in fact). If the privilege were abrogated, Hiss could, in the case assumed, have summoned the psychiatrist and compelled him to testify. This might have been of the utmost value, as, for example, if the psychiatrist had been forced to state that from his examination and treatment he was convinced that Chambers was a pathological liar. The suppression of such evidence by operation of the privilege may work the most outrageous in-

justice, in that it may result in the conviction of an innocent man on the testimony of a witness who, but for the privilege, could have been shown to be unworthy of belief. On the other hand, what would have been the effect on the willingness of neurotic or psychotic individuals to consult a psychiatrist if they read in the front-page newspaper accounts of such a sensational case that a psychiatrist could be summoned by one's opponent to reveal in the courtroom what one had confessed in strictest confidence in the consulting room? The question is not without difficulty, but we submit that the possible injustice that might be done by the suppression of evidence in individual cases is outweighed by the importance of assuring patients that the confidentiality of their relations with their psychiatrist is absolute, and not subject to violation even on a court summons.

The balance of interests may not be the same in criminal as in civil cases. It may be argued that even if the privilege is allowed in civil litigation, no doctor—psychiatrist or other—should be allowed to refuse to reveal to the agencies of the state information relevant to the detection and prosecution of crime. In several states the privilege is restricted to civil cases.[4] In others, it is expressly made inapplicable to certain situations where it might defeat strong public policy, as in abortion, venereal or narcotic cases.[5] But we believe that the rationale of these policy exceptions does not extend to denying in all criminal cases the privileged status of communications made in the course of psychotherapy. The amount of good society might derive from obtaining a certain number of additional convictions by the help of the psychiatrist's testimony would almost certainly be outweighed by the harm done in destroying the confidentiality of the psychiatrist-patient relationship. Punishment is not that much more important than therapy.

Except for the Illinois trial court decision already referred to, and a 1948 Kentucky statute,[6] we know of no legal support for our suggestion that there is greater reason for the privilege in phychiatric than in other medical cases. On the contrary, in some states cases of mental and emotional disorders are perhaps excluded from the statutes creating the privilege for doctor-patient communications generally. This peculiar situation results where the privilege is extended only to

4. CAL. CODE CIV. PROC. § 1881(4) (Deering 1946); IDAHO CODE ANN. § 9-203(4) (Cum. Supp. 1951); ORE. COMP. LAWS ANN. § 3-104(a) (1940); PA. STAT. ANN. tit. 28, § 328 (1939); S.D. CODE § 36.0101(3) (1939); UTAH CODE ANN. § 104-49-3(4) (1943).

5. WIGMORE, EVIDENCE §§ 220, 2380.

6. KY. REV. STAT. § 319.110 (1948).

"licensed" or "authorized" physicians, and where the licensing acts do not apply to the treatment of mental and emotional disorders.[7] In these states, a psychiatrist practicing without a medical license, as he legally may do, would clearly not be within the privilege. And the same may be true notwithstanding that he does have a license to practice medicine, on the theory that when he administers psychiatric therapy he is not engaging in the "practice of medicine" as defined by the statute and is therefore not within the privilege so far as such cases are concerned. There seem to be no cases on the point.

Most of the statutes extend the privilege to all physicians and surgeons without reference to whether they are licensed or not.[8] Such statutes would seem to include phychiatrists, for psychiatrists are physicians, *i.e.,* they are doctors of medicine specializing in psychiatry. A psychologist, on the other hand, is not a doctor of medicine; he is not a graduate of a medical school. If he holds a doctorate, it is from a liberal arts college, that is, he may be a Ph.D., but he is not an M.D. He is therefore not within the privilege; nor is a lay analyst—a psychoanalyst who is not licensed to practice medicine. Nor are nurses or hospital attendants privileged, except when acting as assistants or agents of physicians.[9] Faith healers, osteopaths and chiropractors are not within the privilege[10] except where they are within the state definition of physicians and surgeons.

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7. ARK. STAT. ANN. tit. 72, § 617 (1947); ME. REV. STAT. c. 61, § 8 (1944); MASS. ANN. LAWS c. 112, § 7 (1949); MINN. STAT. ANN. § 147.10 (Cum. Supp. 1951); N.J. STAT. ANN. § 45.9-18.1 (1937); N.C. GEN. STAT. ANN. § 90.18 (1950); OHIO CODE ANN. § 1286 (Supp. 1950); OKLA. STAT. tit. 59, § 492 (1941); S.D. CODE c. 106, § 14 (1949); TENN. CODE ANN. § 6937 (Michie Supp. 1950); WASH. REV. STAT. ANN. § 10024 (1932); WIS. STAT. § 147.19(2) (1949). In Arkansas, South Dakota, Tennessee, and perhaps other of these states, so-called basic science laws require the passing of an examination in the "basic sciences" before one can practice any of the healing professions. See Note, *Regulation of Psychological Counseling and Psychotherapy,* 51 COL. L. REV. 474 (1951).

8. "Fifteen of the statutes extend the privilege generally to physicians and surgeons or to physicians alone, two limit it to 'regular' physicians and surgeons, and nine apply it only to licensed or authorized physicians and surgeons. The five remaining statutes use language which, in addition to covering physicians and surgeons, embraces other persons connected with medical treatment." Note, 52 COL. L. REV. 383, 391 (1952).

9. First Trust Co. v. Kansas City Life Ins. Co., 79 F.2d 48 (1935) (nurse-dietitian); Southwest Metals Co. v. Gomez, 4 F.2d 215 (1925) (nurse assisting doctor); Laurie Co. v. McCullough, 174 Ind. 477, 90 N.E. 1014 (1909) (gymnasium teacher of exercises prescribed by physician); Miss. P. & L. Co. v. Jordan, 164 Miss. 174, 143 So. 483 (1932) (nurse assisting physician); Culver v. Union Pacific R.R., 112 Neb. 441, 199 N.W. 794 (1924); Prudential Ins. Co. v. Kozlowski, 226 Wis. 641, 276 N.W. 300 (1937) (nurse and X-ray operator). See Notes, 169 A.L.R. 678 (1947); 22 MARQ. L. REV. 211 (1938); 68 A.L.R. 176 (1930); 39 A.L.R. 1421 (1925).

10. *In re* Mossman's Estate, 119 Cal. App. 404, 6 P.2d 576 (1931) (Christian Science practitioner); Kress & Co. v. Sharp, 156 Miss. 693, 126 So. 650 (1930) (chiropractor).

Wholly apart from any legal privilege, it would be unethical for a psychiatrist to imply that an interview was confidential and then to disclose it to the agencies of the state. A confession obtained by improper influences exerted by a psychiatrist working for the prosecution has been held inadmissible in evidence by the New York Court of Appeals.[11]

Both the American Psychoanalytic Association and the American Psychiatric Association were aroused some time ago by an editorial written by J. Edgar Hoover, director of the Federal Bureau of Investigation, for the Journal of the American Medical Association, in which he urged physicians to report any of their patients whom they suspect of subscribing to subversive ideology.[12] It was felt that knowledge by patients that psychiatrists engage in such a practice would do far more harm by its adverse effect on treatment than any good it could possibly do the government, and that such an "invitation," if accepted, might soon lead to more insistent attempts to force physicians to disclose confidences of their patients.

In England, it seems to be considered unethical for the examiner even to discuss the circumstances surrounding the crime with the suspect, let alone to reveal his statements to the authorities. This seems to go very far, for it is difficult to see how a psychiatrist can examine a subject for the purpose of determining his capacity to understand the nature and quality of his act without touching on the circumstances surrounding its commission. But a psychiatrist making an examination for the prosecution certainly should explain to the defendant or suspect that notes are being taken and that a report will be sent to the court or other official agency, and should advise him that he may decline to answer questions which he does not want included in the report. Such a concession will not usually lead the subject to withhold information. He will, typically, be willing and even anxious to tell his side of the story to the psychiatrist.

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11. "Bearing in mind," said the court, "the undisputed setting in which this interview was arranged and recorded, while defendant was in custody of the police; defendant's physical and mental condition at the time . . .; the psychiatrist, calling himself defendant's doctor, playing upon the latter's natural fears and hopes, pressing his hands upon defendant's head with accompanying commands, and suggesting details to an unwilling mind by persistence and unceasing questioning; informing defendant that he was not morally responsible; making deceptive assurances of friendship and numerous promises, express and implied; giving assurances in a pseudo-confidential atmosphere of physician and patient; and all the attendant circumstances taken together—this interview was a subtle intrusion upon the rights of defendant and was tantamount to a form of coercion, which, despite the good faith of the prosecution, we may not countenance here." People v. Leyra, 302 N.Y. 353, 96 N.E.2d 553 (1951).

12. Hoover, *Let's Keep America Healthy,* 144 A.M.A.J. 1094, 1095 (1950).

The medical profession should properly insist upon a high standard of ethics in preserving the confidences of clients. Even without the statutory privilege, there is no legal obligation on a doctor or anyone else to volunteer information to the police, or to the FBI, or even to answer questions by police agencies. It is only where the physician is summoned by judicial process to appear in court and give testimony in a legal proceeding that he can be compelled to speak, in absence of the privilege. Against disclosures outside the court room the legislatures have provided no protection. So far as statutes go, the doctor may with legal impunity chat about the case at a cocktail party or describe it in detail in a medical journal. Legal protection here is afforded only in so far as the courts might find an invasion of the right of privacy, and recovery on this ground will be allowed only if the publication went beyond the limits of reasonableness and decency.[13] In the main, the patient's confidences are protected against disclosure outside the court room primarily by the code of professional ethics rather than by the law.

The privilege does not apply where the doctor merely observes a defendant while in confinement, or examines him at the instance of the other party or the court for purpose of testifying at his trial, for that does not constitute attending a patient in a professional capacity.[14] But it has been held that it does apply where the doctor administers treatment, even though the person was not a voluntary patient, as where he was brought to a clinic by the police for examination, or where he was unconsicous at the time.[15] By the same token, the privilege has been held to exist between an inmate of a mental institution and staff

13. See Simonsen v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920); Challender, *Doctor-Patient Relationship and the Right of Privacy,* 11 U. PITTS. L. REV. 624 (1950).

14. San Francisco v. Superior Court, 37 Cal.2d 227, 231 P.2d 26 (1951); State v. Fouquette, 221 P.2d 214 (Nev. 1950); People v. Barnes, 197 Misc. 447, 98 N.Y.S. 481 (1950); Hanlon v. Woodhouse, 113 Colo. 504, 160 P.2d 998 (1945); People v. Dutton, 62 Cal. App.2d 862, 145 P.2d 678 (1944); State v. Newsome, 195 N.C. 552, 143 S.E. 187 (1928); State v. Murphy, 205 Ia. 1130, 217 N.W. 225 (1928); People v. Furlong, 187 N.Y. 198, 79 N.E. 978 (1907); 1 WEST. RES. L. REV. 142 (1949); 107 A.L.R. 1491, 1495 (1937).

15. Clapp v. State, 73 Okla. Cr. 261, 120 P.2d 381 (1941); Palmer v. Order of United Comm. Travelers, 187 Minn. 272, 245 N.W. 146 (1932); Battis v. Chicago, R. I. & P. Ry., 124 Ia. 623, 100 N.W. 543 (1904). In the first case, Clapp killed a person driving his car and was charged with manslaughter. The testimony of the physician and the nurse at the hospital to which he was brought after the accident was that when they examined him they detected liquor on his breath, was held inadmissible. See other cases collected in Note, 79 A.L.R. 1131 (1932). In Meyer v. Knights of Pythias, 178 N.Y. 63, 70 N.E. 111 (1904), a hotel called a doctor to attend a guest. The latter said he had taken poison and objected strenuously to the doctor's doing anything for him. The doctor did succeed in administering a hypodermic. In a suit for the life insurance benefit, the doctor was not allowed to testify about the poison, a highly relevant matter because the policy provided for forfeiture in case of suicide.

doctors.[16] So far has the privilege been extended beyond the original premise of protecting confidential communications that courts assume without argument that all statements of inmates to hospital doctors come within the rule.

Even where the doctor-patient relation clearly exists, it is only information coming to the doctor in the course of that professional relation which is privileged If he has known the patient socially, there can be no objection on the ground of privilege to his testifying to what he learned through such contacts.[17] Thus, he can testify to hearing the patient make threats against his wife, since that was not part of the professional relationship.[18]

But this line between statements made in the course of professional treatment and other statements is not always an easy one to trace. This is particularly true in psychiatric cases. In the case mentioned above, while the patient's threats against his wife may be clearly outside the professional relationship if the doctor who heard them were treating him for bronchitis, they would probably be of the highest professional relevance if the doctor were administering psychiatric treatment. Indeed, psychoanalytic theories regarding the unconscious make practically everything the patient says relevant, even though the relevance may not be logically apparent. The analyst himself is really the only one competent to say whether a given statement made to him by the patient in the course of examination or treatment comes within the rule.[19]

The privilege belongs to the patient, not the doctor. If the patient consents to the testimony, the doctor has no basis for refusing to answer.[20] For the same reason, the patient cannot be forced to testify to such privileged communications any more than the doctor can.

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16. Linscott v. Hughbanks, 140 Kan. 353, 37 P.2d 26 (1934).

17. Watkins v. Watkins, 142 Miss. 210, 106 So. 753 (1926).

18. Myers v. State, 192 Ind. 542, 137 N.E. 547 (1922). A doctor can testify that a patient being treated following an accident was intoxicated, for that was not information communicated to him by the patient to enable the doctor to treat him. State v. Townsend, 146 Kan. 982, 73 P.2d 1124 (1937). But some cases hold everything divulged in the course of the physician-patient relationship to be privileged. McRae v. Erickson, 1 Cal. App. 326, 82 Pac. 209 (1905); Brayman v. Russell & Pugh Lumber Co., 124 Ia. 623, 100 N.W. 543 (1904); Munz v. R. Co., 25 Utah 220, 70 Pac. 852 (1902); Pennsylvania Co. v. Marion, 123 Ind. 415, 23 N.E. 973 (1889); 7 L.R.A. 687 (1890); 18 Am. St. Rep. 330 (1890).

19. Even in non-psychiatric cases, at least a minority of states hold that the physician and not the trial judge determines whether the information acquired was necessary for treatment. Johns v. Clark, 138 Wash. 288, 244 Pac. 729 (1926); Note, 13 WASH. L. REV. 141 (1938).

20. Doty v. Crystal Ice & F. Co., 118 Kan. 363, 235 Pac. 96 (1925); Angerstein v. Milwaukee Monument Co., 169 Wis. 502, 173 N.W. 215 (1919).

In a Kansas case,[21] a doctor was sued for alleged negligence in performing a hysterectomy. Plaintiff introduced evidence that after the operation, the patient, plaintiff's wife, was not able to control her bladder. Shortly after the series of operations, the woman had been committed to the state hospital as insane. The doctor-defendant offered as a witness a staff doctor of the hospital to prove that the latter had examined her after her admission and concluded that her incontinence was not caused by the operations but by lack of conscious control of the sphincter muscle due to her mental condition, and that it ceased within a week after her admission. This was objected to as privileged. The defendant argued: (1) that the doctor-patient relation did not exist here, since the woman had never voluntarily entered into such a relation with the staff physician of the hospital to which she had been committed, and the treatment accorded her at such hospital is a matter open to public inquiry; and (2) that if the privilege existed, it had been waived by plaintiff's having testified fully about the operations and her mental condition. The court held that the privilege extends to relations between a patient committed to a mental institution and a staff doctor, and that it had not been waived, because the plaintiff had not testified to the very transactions which defendant wanted the hospital doctor to testify to. Plaintiff had testified to the fact that his wife had been confined in the state hospital, but not to the examinations there made. This seems an unjusifiably narrow view of the waiver rule.

Suppose a patient has died since the consultation; can anyone now give valid consent to the doctor's testifying? Most statutes provide that his administrator or executor may give the consent, but a few fail to cover this contingency. In such states, the privilege designed to protect the patient may defeat his desires, for cases have arisen where it is fairly clear that if alive, he would have wanted the doctor to speak. In a will case, [22] where it was alleged that the testator suffered from general paresis (which, as it is well known, is caused by syphilis), a physician who had examined him was not permitted to testify on the basis of his examination of the deceased that he was of sound mind, even though the physician was offered as a witness by the sole heir at law of the deceased and his administratrix and personal representative. The privilege, the

21. Linscott v. Hughbanks, 140 Kan. 353, 37 P.2d 26 (1934).

22. Watkins v. Watkins, 142 Miss. 210, 106 So. 753 (1926). For other Mississippi cases illustrating the objections to the rule, see Lipscomb, *Privileged Communications Statute—Sword and Shield,* 16 MISS. L.J. 181 (1944). Mississippi has since amended its statute to permit the privilege to be waived by the personal representative or legal heirs of the patient, where he has since died. MISS. STAT. 1944, c. 315, p. 540. For cases from other states see 8 WIGMORE, EVIDENCE § 2391; Note, 126 A.L.R. 167 (1924).

court said, could be waived only by the patient himself. Although it said that the "manifest reason and obvious purpose of the statute was to enable a patient to disclose his infirmities to his physician in order that the physician may prescribe for his disease without fear that his feelings will be shocked or his reputation tarnished by their disclosure by the physician without his consent," the court here applied that "manifest reason and obvious purpose" to prevent a doctor from refuting the attempt to tarnish the dead man's reputation.

However, what the court excluded by one legal technicality, it managed to let wriggle in by another. This same doctor, after stating that he could segregate in his mind the knowledge he had acquired about the condition of the testator from having been his physician from what he had acquired from social contact with him, was permitted to testify that in his opinion the testator was of sound mind. Of course, this required carefully putting to one side any scientific basis for his opinion, and resting it wholly on casual social contacts. It also required the trial judge to determine whether the doctor was able thus to segregate his knowledge coming from the one source from that coming from the other. Psychologists are, of course, unanimous in their view that such an actual division is impossible.[23] Another doctor who had also treated the testator was permitted to testify, not to what he actually had learned on professional examination, but to his abstract opinion in answer to hypothetical questions. It is easy to ridicule this result, and yet it is perfectly sound under the legal premises on which the exclusionary rule is based.

It has been held that the patient does not waive the privilege by introducing another physician to testify about the same facts.[24] The sounder rule is that calling one physician to testify to one's condition is a waiver of the privilege as to the testimony of other physicians regarding such condition.[25] Indeed, the mere fact of bringing suit raising a

23. At least one court has also pointed out this impossibility: "The human mind is not competent to separate the facts of which it is cognizant into classes—those which were obtained professionally and those facts coming within the observation of the witness not so obtained—and distinguish an opinion derived from one series of facts from an opinion derived from another." Larson v. State, 92 Neb. 24, 137 N.W. 894 (1912).

24. Johnson v. Kinney, 232 Ia. 1016, 7 N.W.2d 188 (1942); Russell v. Penn. Mut. Life Ins. Co., 70 Ohio App. 113, 41 N.E.2d 251 (1941); and cases cited in 8 WIGMORE, EVIDENCE § 2390. See Notes, 51 HARV. L. REV. 931 (1938); 31 YALE L.J. 529 (1922); 62 A.L.R. 680 (1929).

25. State v. Cochran, 356 Mo. 788, 203 S.W.2d 713 (1947); Denny v. Robertson, 352 Mo. 609, 179 S.W.2d 5 (1944); Leifson v. Henning, 210 Minn. 307, 298 N.W. 41 (1941); Albritton v. Ferguson, 197 Ark. 436, 122 S.W.2d 620 (1938); Keeton v. State, 175 Miss. 631, 167 So. 68 (1936); *Re* Quick's Estate, 161 Wash. 537, 297 Pac. 178 (1931).

medical issue should be deemed a waiver of the privilege for all communications to any physicians concerning such issue. No court has been willing to go so far, but in California the legislature has provided that bringing suit for personal injuries or for wrongful death waives the privilege as to any physician who has "prescribed for or treated" the plaintiff or who "attended" the deceased.[26] Where a person not merely brings suit but voluntarily testifies to his medical condition, a number of courts hold the privilege waived.[27] It would seem proper to apply this to psychiatric as well as to other medical cases. Notwithstanding what we have said regarding the need for inviolability of psychiatric confidences, when a plaintiff, who is himself fully competent, voluntarily makes his mental condition an issue in a judicial proceeding, and especially if he himself testifies as to his condition, he can properly be said to have waived confidentiality. Even here, however, immaterial confidences and irrelevant details of confidences would of course be excluded and courts should be vigilant not to require unnecessary exposures.

Under the Federal Rules of Civil Procedure and in those states that have adopted similar rules, the operation of the privilege may be effectively cut down by Rule 35, which authorizes the trial court to order examination by a physician of a party whose mental or physical condition is in controversy. If the party so examined requests and obtains a copy of the physician's report (which he will ordinarily want, for purposes of cross-examination), he thereby waives any privilege regarding the testimony of any other person who has examined him. Although this might be said in practical effect to empower the trial judge to deprive a party of the privilege, we believe that even this rule is still sufficiently restricted so that it does not too seriously invade the confidentiality of communication. First, it is limited to parties, and does not extend to mere witnesses. Second, it becomes operative only where the judge orders an examination. The order is not to be made except "for good cause shown," and the judge would presumably not so order unless the question of the party's condition appears to be a substantial one. Third, the party to be examined is allowed a voice in choosing the court-appointed physician. If he strenuously objects to the physician proposed by the other side, the court will ordinarily appoint someone else, preferably someone on whom the parties can agree. And finally, the

26. CAL. CODE CIV. PROC. § 1881 (4) (Deering 1946).

27. 8 WIGMORE, EVIDENCE § 2389. See also cases collected in 114 A.L.R. 798 (1938): 62 A.L.R. 680 (1929); Notes 51 HARV. L. REV. 931 (1938); 31 YALE, L.J. 529 (1922). Two recent cases illustrate the split in court viewpoints: Hudman v. State, 89 Okla. Cr. 160, 205 P.2d 1175 (1949), holding that taking the stand oneself and offering one physician as a witness waives the privilege as to other physicians; Harrington v. Hadden, 69 Idaho 22, 202 P.2d 236 (1949), *contra.*

party may still keep the privilege regarding communications to other physicians if he wants to do so, by foregoing asking to see a copy of the report. This is a high cost only to the party who has reason to fear that the report will disagree with his own evidence.

In summary, we believe that the question of whether a physician-patient privilege is sound and should be legally recognized ought not to be debated in general terms, but should be resolved into specific types of physician-patient relationships, taking into account for each type both the therapeutic importance of confidentiality and, on the other hand, the evidence of abuse in practice. Specifically, we believe that psychiatric therapy requires a peculiarly close relationship of trust and confidence between therapist and patient, and that it is not one of the fields where abuse is notably prevalent. As in most fields, we are not limited to black and white answers. Careful study of the problem should enable us to devise a rule recognizing the privilege subject to limitations adequate to prevent abuse.