Group for the Advancement of Psychiatry: Confidentiality and Privileged Communication in the Practice of Psychiatry

Henry Weihofen
The University of New Mexico

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The physician-patient privilege, a product of 19th century reform, became of major significance only under 20th century socialized medicine. The 19th century doctor was a wholly private practitioner; his sole concern was for the health of his patient, and medical ethics justified keeping confidential the fact that his patient had "galloping consumption," typhoid fever or a loathsome disease.

But with the rise of preventive medicine and community health concepts, with the growth of life and accident insurance, workmen's compensation and the expansion of common carrier liability, the doctor has been shouldered with two disparate sets of duties: the ethical duty to his patient to respect his confidences, and a moral or even legal duty to disclose information important to public health and safety. These frequently conflict, and the doctor faces the dilemma of choosing between them.

Not only has the scope of the privilege been increasingly impinged upon by considerations of public protection, but leading authorities in the law of evidence have rather unanimously taken the view that the privilege serves no useful purpose and should be abolished. General practitioners of medicine also find it of no importance to them.

At the same time, however, the privilege has come to be of great importance in a specialized field of medicine that hardly existed when most of the statutes were written—the practice of psychiatry. Although the automobile accident victim may have little legitimate reason for silencing his doctor, the psychiatric patient may have very compelling reasons. The psychiatrist must insist on very personal data, and must explore the relationship of the patient's act to his basic drives which can be adequately revealed only by his deepest and most secret thoughts and feelings. "The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he
lays bare his entire self, his dreams, his fantasies, his sins, and his shame."1
The relationship is closer to that of priest and penitent than to that of the
ordinary general practitioner and his patient. Some of the things the
psychiatric patient must tell his therapist about, such as marital infidelities
and sexual perversion, obviously may lead to litigation, and the patient
might hesitate to speak frankly if he knew that his psychiatrist could later
be compelled to testify. Whatever objections might be made to the
privilege in other kinds of medical practice, confidentiality is a sine qua
non for successful psychiatric treatment.

This small pamphlet, prepared by the Group for the Advancement of
Psychiatry by its committee on psychiatry and law, under the chairmanship
of Dr. Andrew S. Watson of the University of Michigan, undertakes to tell
the psychiatrist what he needs to know not only about the legal privilege
but also the ethical professional obligation of confidentiality.

The advent of “scientific medicine,” as the committee says, plus modern
institutionalization and modern emphasis on records, has increased the
likelihood that confidentiality may be broken. Most of the situations in
which the law today requires exposure come under two headings: matters
relating to public health and matters relating to crime. In the area of
public health, the law in many states now imposes a positive legal duty on
physicians to report cases of certain named communicable diseases and
perhaps other maladies and injuries such as cancer, occupational diseases,
injuries to workmen compensable under workmen’s compensation laws,
cerebral palsy, epilepsy, drug addiction and others.

The pamphlet also discusses problems that arise when the psychiatrist is
treating the patient in a capacity that ties his allegiance to a party or
agency whose interest may be adverse, as when he is acting in the capacity
of prison psychiatrist. It also discusses the problem of hospital and office
records and developments in the processing of records arising out of the
institution of “social service exchanges” which act as clearing houses
through which public and private agencies exchange information.

In matters relating to crime, the physician has the same duty as any
other citizen to assist in the discovery and apprehension of criminals. The
GAP pamphlet hardly touches on the problems that the psychiatrist faces
when he discovers to his dismay that his patient has committed a crime or
is seriously likely to commit a crime, or when a woman patient informs
him that another doctor has performed an illegal abortion upon her.
Problems such as these have been the subject of much discussion in England
recently, but there has been very little such discussion in this country. A
similar question arises when the psychiatrist has a patient who is subject to
“blackout” fits due to epilepsy or some other mental disorder, yet insists on
driving an automobile. Nor is there any discussion of such questions as
whether the psychiatrist should talk when questioned by governmental

1 GUTTMACHER & WEIHOFFEN, PSYCHIATRY AND THE LAW 272 (1952).
security agencies or congressional investigating committees about homo-
sexual or other immoral or criminal conduct of patients who may be
governmental employees, a subject that the District of Columbia Medical
Society had occasion to debate not long ago.

The GAP committee proposes a statute that would put the psychiatrist-
patient privilege on the same basis "as provided by law between attorney
and client." This would generally make the privilege broader than the
physician-patient privilege, which as already said usually contains many
exceptions. (In a few states, psychologists have in recent years obtained
statutory recognition of a privilege for their professional communications;
these are usually specifically made to refer to the attorney-client privilege,
with the result that the psychologist privilege is broader than that for
communications to physicians, including psychiatrists.)

The device of defining the scope of the privilege by reference to the
attorney-client privilege might be satisfactory if the scope of the latter were
clear, but it is not. The delimitation of situations in which that privilege
does not exist is itself a complicated area of law. The American Bar As-
sociation in 1938 recommended a flexible statute, such as that of North
Carolina, which contains a proviso allowing a judge to compel disclosure
"if in his opinion the same is necessary to the proper administration of
justice." While flexibility may be desirable to allow some exceptions, it
fails to serve the essential purpose of the privilege: the patient can never be
sure that his confidences will be kept inviolate. Professor Slovenko has
suggested a wording which would go to the other extreme, of making the
communication "absolutely privileged." But absolute rules are usually
too rigid. Granting that communications between psychiatrist and patient
call for statutory protection, the formulation of a statutory provision
deserves more careful collaborative study by the legal and medical profes-
sions than it has yet received.

But this little pamphlet would not be the place for such a discussion.
Its purpose is to inform the psychiatrist about some of the questions of
confidentiality and privilege that he is likely to encounter. And while, as
said, it does not cover all these questions, that is perhaps intentional. To
discuss them all would perhaps be to commit that all-too-common sin of
pedants, of telling people more about a subject than they care to know.

Henry Weihofen,
Professor of Law,
The University of New Mexico

2Pollack v. United States, 202 F.2d 281 (5th Cir. 1953) (lawyer acting as business
agent or accountant not within the privilege); In re Selser, 15 N.J. 393, 105 A.2d 395 (1954)
(communication concerning intended "wrongful" acts not privileged); Note, 47 Mich. L.
Rev. 416 (1949).

3See Model Code of Evidence, rules 220-223 (1942).

4Slovenko, Psychiatry and a Second Look at the Medical Privilege, 6 WAYNE L. REV.
175, 203 (1960).