#63.20-70 4/8/74

Memorandum 74-19

Subject: Study 63.20-70 - Evidence (Evidence Code Section 999)

Senate Bill 1534 was introduced by Senator Stevens to effectuate the Commission's recommendation relating to Evidence Code Section 999--The "Criminal Conduct" Exception to the Physician-Patient Privilege. The bill would repeal Section 999.

There is substantial opposition to this recommendation. The State Bar, California Trial Lawyers Association, and State Department of Health oppose the recommendation.

The opposition ignores the lack of logic for the exemption; instead, the opposition is based on an unwillingness to make privileged some evidence that is now available.

You will recall that the Commission decided not to eliminate entirely the physician-patient privilege because it agreed with Justice Kaus that the privilege should be available to protect nonparty patients in a malpractice action. The privilege would protect against discovery of the names of other patients treated by a physician to determine what the physician's normal practice was in a particular type of case. The staff believes that the privilege is justified to protect patients who are not parties. However, where the patient is the plaintiff, the privilege does not exist as to any "communication relevant to an issue concerning the condition of the patient if such issue has been tendered by . . . the patient" or other party claiming by or through the patient. Evidence Code Section 996. Also the privilege does not apply in a criminal proceeding (Section 998) or in various other instances. There is, however, no general exception for the case where the communication is relevant to an issue in the proceeding and the patient is a party to the

proceeding. We think that such an exception should be substituted for the "criminal conduct" exception. By making such an exception, we would eliminate the need for the court to try the criminal action to determine whether the exception applies; instead, whether the exception applies would depend upon whether the communication is relevant to an issue in the proceeding. At the same time, nonparty patients would be protected against disclosure of their communications to their physicians. We think that this is sufficient protection and that the proposed exception would not inhibit communications between patients and their physicians.

Accordingly, we recommend that Section 999 be amended to read as follows:

> 999. ~~There~~ Where the patient is a party to the proceeding, there is no privilege under this article ~~in-a-proceeding-to-recover-damages-on account-of-conduct-of-the-patient-which-constitutes-a-crime~~ as to a communication relevant to an issue concerning the condition of the patient .

If this proposal is satisfactory to the Commission, we will suggest that Senator Stevens amend Senate Bill 1534 as set out above and then set the bill for hearing.

By way of background information, you will find attached to this memorandum:

(1) An extract from McCormick's Hornbook on Evidence (green).

(2) An extract from Wigmore on Evidence (yellow).

(3) A Yale Law Review Note discussing the physician-patient privilege (pink).

Respectfully submitted,

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Executive Secretary

105. The Policy and Future of the Privilege.[85]

Some statements of Buller, J., in 1792 in a case involving the application of the attorney-client privilege seem to have furnished the inspiration for the pioneer New York statute of 1828 on the doctor-patient privilege. He said: "The privilege is confined to the cases of counsel, solicitor, and attorney. . . . It is indeed hard in many cases to compel a friend to disclose a confidential conversation; and I should be glad if by law such evidence could be excluded. It is a subject of just indignation where persons are anxious to reveal what has been communicated to them in a confidential manner. . . . There are cases to which it is much to be lamented that the law of privilege is not extended; those in which medical persons are obliged to disclose the information which they acquire by attending in their professional characters."[86]

These comments reveal attitudes which have been influential ever since in the spread of statutes enacting the doctor-patient privilege. One attitude is the shrinking from forcing anyone to tell in court what he has learned in confidence. It is well understood today, however, that no such sweeping curtain for disclosure of confidences in the courtroom could be justified. Another is the complete failure to consider the other side of the shield, namely, the loss which comes from depriving the courts of any reliable source of facts necessary for the right decision of cases.

Perhaps the main burden of Justice Buller's remarks, however, is the suggestion that since the client's disclosures to the lawyer are privileged, the patient's disclosures to the doctor should have the same protection. This analogy has probably been more potent than any other argument, particularly with the lawyers in the legislatures. They would be reluctant to deny to the medical profession a recognition which the courts have themselves provided for the legal profession. Manifestly, however, the soundness of the privilege may not be judged as a matter f rivalry of professions, but by the criterion of the public interest. It has been persuasively urged that the same need for the protection of the patient's confidences as in the case of the client's communications does not exist.[87] As the client considers what he shall reveal to his lawyer he will often have

85. There is a wealth of cogent discussion of the policy of the privilege. All that I have seen are adverse. Wigmore's scalpel cuts deepest. 8 Evidence (McNaughton rev.) § 2380a. Other excellent discussions: De Witt, Privileged Communications Between Physician and Patient, Ch. IV (1958); Chafee, Is Justice Served by Closing the Doctor's Mouth?, 52 Yale L.J. 607 (1943); Purrington, An Abused Privilege, 6 Colum.L.Rev. 388 (1906) (historical, comparative, critical); Notes, 33 Ill.L.Rev. 483 (1939), 12 Minn.L.Rev. 390 (1928). See also for worthwhile treatments: Welch, Another Anomaly—the Patient's Privilege, 13 Miss.L.J. 137 (1941) (emphasis on local decisions); Curd, Privileged Communications between Doctor and Patient —an Anomaly, 44 W.Va.L.Q. 165 (1938); Long, Physician-Patient Privilege Obstructs Justice, 25 Ins.Counsel J. 224 (1958).

86. Wilson v. Rastall, 4 Term Rep. 753, 759, 100 Eng. Rep. 1287 (K.B.1792).

The Revisers who drafted the New York statute, supported it in their report as follows: "In 4 Term, Rep. 580, Buller, J. (to whom no one will attribute a disposition to relax the rules of evidence), said it was 'much to be lamented' that the information specified in this section was not privileged. Mr. Phillips expresses the same sentiment in his treatise on evidence, p. 104. The ground on which communications to counsel are privileged, is the supposed necessity of a full knowledge of the facts, to advise correctly, and to prepare for the proper defense for prosecution of a suit. But surely the necessity of consulting a medical adviser, when life itself may be in jeopardy, is still stronger. And unless such consultations are privileged, men will be incidentally punished by being obliged to suffer the consequences of injuries without relief from the medical art and without conviction of any offense. Besides, in such cases, during the struggle between legal duty on the one hand, and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will in most cases furnish a temptation to the perversion or concealment of truth, too strong for human resistance. In every view that can be taken of the policy, justice or humanity of the rule, as it exists, its relaxation seems highly expedient. It is believed that the proposition in the section is so guarded, that it cannot be abused by applying it to cases not intended to be privileged." Original Reports of Revisers, vol. 5, p. 34, quoted Purrington, op. cit., 6 Colum.L.Rev. 392, 393.

87. See especially the discussions of Wigmore and Chafee, cited in note 85, supra. Compare, however, recent suggestions, supported by a trial court decision, that confidences to a psychiatrist stand on a special footing and should be privileged even

in mind the possibility of the exposure of his statements in court, for the lawyer's office is the very anteroom to the courthouse. The patient, on the other hand, in most instances, in consulting his doctor will have his thoughts centered on his illness or injury and his hopes for betterment or cure, and the thought of some later disclosure of his confidences in the courtroom would not usually be a substantial factor in curbing his freedom of communication with his doctor. Accordingly, the justification in the need for encouraging the frank disclosure of information to the doctor seems to have slight relevancy to the actual play of forces upon the average patient.

Doubtless the willingness of the doctors to advocate the adoption of privilege statutes is in large part due to their esteem for the tradition, dignity and honor of the profession. The tradition of respect for the confidences of the patient is an ancient and honorable one. But the Hippocratic oath does not enjoin absolute secrecy on all occasions,[88] and doubtless the modern oaths of secrecy could well be understood as being subject to justified departure for the saving of life or in conformity with the requirements of law in the interest of justice. Actually, this practice of the physician in his everyday walks of abstaining from gossiping about his patients, of which the doctor's honor, and not the law, is the guardian, is a far more important factor in inspiring frankness in the patient than any courtroom privilege can be.[89]

Nor does the privilege in fact usually operate to protect against public exposure of humiliating facts. Usually the facts are not shameful, save as they may disclose falsehood in the patient's claims, and the various contentions as to what the facts are, are fully and publicly made known in the pleadings, the opening statements and the other testimony.[90]

If actually the chief effect of the privilege is to enable the patient to tell on the witness-stand a story of his ailment, injury or state of health, without contradiction from his physician whose testimony would prove the first story to be untrue, does such a privilege, and such enforced silence, promote the honor and dignity of the medical profession?

In a rare case, one will read between the lines a situation in which a doctor, after examining or treating a patient, will for mercenary motives betray his secrets before litigation to the defendant who has injured the patient, or to a life insurance company against whom the patient's family has a claim. Such rare cases, however, lend little support to the privilege. Despite his disloyalty the testimony of such a doctor may be

though a general patient's privilege is not recognized. Notes, Guttmacher and Weihofen, 28 Ind. L.J. 32 (1952), 47 Nw.U.L.Rev. 384 (1952); F.R.Ev. (R.D.1971) 504 and Advisory Committee's Note.

88. See Purrington, op. cit., 6 Colum.L.Rev. at 395, and see the discussion of the scope and effect of this oath in Morrison v. Malmquist, 62 So.2d 415 (Fla.1953) and in the able article, Dewitt, Medical Ethics and the Law, 5 West Reserve L.Rev. 5, 7 (1953).

89. Purrington calls attention to art. 378 of the French Code Pénal which makes the doctor's disclosure of a medical secret, *except under compulsion of law*, punishable by fine and imprisonment, and he adds this comment: "Litigation is too uncommon an incident in the life of the average man for the anticipation of it to prove a deterrent. Gossip, on the other hand, and the desire to publish scientific, or pseudo-scientific papers are constant temptations to violation of confidence. Yet the physician is left free under our law to prattle at will of his patient's condition and affairs, subject in remote contingencies to a civil action for damages, and is forbidden to speak of them only when the interests of justice demand disclosure of that truth which the patient, it may be, is suppressing or misrepresenting in court." 6 Colum.L.Rev. at pp. 394, 396, 397.

90. See 8 Wigmore, Evidence (McNaughton rev.) § 2380a, p. 830, where he says: "From asthma to broken ribs, from ague to tetanus, the facts of the disease are not only disclosable without shame, but are in fact often publicly known and knowable by everyone—except the appointed investigators of truth."

true, and a judge or jury when his motives have been exposed will not be inclined to give undue weight to his story.

It may happen, also, that the privilege will occasionally work in the interest of justice by defeating a life insurance company's defense of misrepresentation by the patient in answering questions as to the past state of his health. Such answers may be of trivial significance and may have been made in good faith. While the privilege which keeps the insured's physician from testifying may happen to obstruct such an unjust defense, the more effective remedy is an enlightened doctrine as to the materiality of the representation, or the requirement of a comprehensive incontestable clause of reasonably short duration.[91]

So much for the benefits which the privilege is supposed to furnish. After the description in the preceding sections of the actual working of the statutes, no detailed recital of the evil results of the privilege is needed. They may be summed up in general terms:

1. The suppression of what is ordinarily the best source of proof, namely, the physician who examined and treated the patient, upon what is usually a crucial issue, namely, the physical or mental condition of the patient.

2. The one-sided view of the facts upon which the court must act when it hears the story of the patient and some doctors selected by him but allows the patient to close the mouth of another doctor whom he has consulted, who would contradict them.

3. The complexities and perplexities which result from a statute which runs against the grain of justice, truth and fair dealing. These perplexities inevitably produce a spate of conflicting and confusing appellate decisions, and encrust the statutes with numerous amendments, reaching for but never attaining the reconciliation of the privilege with the needs of justice.

A palliative for these injustices is the application of the practice of strictly interpreting the statutes creating the privilege[92] rather than the contrary rule of liberally interpreting them, which some courts have espoused.[93]

Among the more sweeping remedies for the evils of the privilege the following should be considered.

First, the adoption of the provisions of the Uniform Rules of Evidence[94] which seem to

91. See 8 Wigmore, Evidence (McNaughton rev.) § 2389(b).

92. Rhodes v. Metropolitan Life Ins. Co., 172 F.2d 183 (5th Cir. 1949); Stayner v. Nye, 227 Ind. 231, 85 N.E.2d 496 (1949); Leusink v. O'Donnell, 255 Wis. 627, 39 N.W.2d 675 (1949); Dec.Dig. Witnesses ⚷208(1).

93. Howard v. Porter, 240 Iowa 153, 35 N.W.2d 837 (1949); People v. Shapiro, 308 N.Y. 453, 126 N.E.2d 559 (1955).

94. Uniform Rule 27: "(1) As used in this rule, (a) 'patient' means a person who, for the sole purpose of securing preventive, palliative, or curative treatment, or a diagnosis preliminary to such treatment, of his physical or mental condition consults a physician, or submits to an examination by a physician; (b) 'physician' means a person authorized or reasonably believed by the patient to be authorized, to practice medicine in the state or jurisdiction in which the consultation or examination takes place; (c) 'holder of the privilege' means the patient while alive and not under guardianship or the guardian of the person of an incompetent patient, or the personal representative of a deceased patient; (d) 'confidential communication between physician and patient' means such information transmitted between physician and patient, including information obtained by an examination of the patient, as is transmitted in confidence and by a means which, so far as the patient is aware, discloses the information to no third persons other than those reasonably necessary for the transmission of the information or the accomplishment of the purpose for which it is transmitted.

"(2) Except as provided by paragraphs (3), (4), (5) and (6) of this rule, a person, whether or not a party, has a privilege in a civil action or in a prosecution for a misdemeanor to refuse to disclose, and to prevent a witness from disclosing, a communication, if he claims the privilege and the judge finds that (a) the communication was a confidential communication between patient and

eliminate the principal abuses of the privilege. This would be a great advance upon most of the existing statutes but these provisions are detailed and complex calling for much judicial labor in their interpretation, and the drafters being human have not been able to foresee and provide against all the possibilities of injustice. The large number of exceptions now found in the more carefully drafted contemporary statutes raises serious doubt as to the scope and validity of what is left of the privilege.[95]

Second, the modification of the privilege-statute by adding a clause, as in the North Carolina Code, "Provided, that the court, either at the trial or prior thereto . . . may compel such disclosure, when, in his opinion, the same is necessary to a proper administration of justice." [96] A clear-eyed and courageous judiciary, trial and appellate,

physician, and (b) the patient or the physician reasonably believed the communication to be necessary or helpful to enable the physician to make a diagnosis of the condition of the patient or to prescribe or render treatment therefor, and (c) the witness (i) is the holder of the privilege or (ii) at the time of the communication was the physician or a person to whom disclosure was made because reasonably necessary for the transmission of the communication or for the accomplishment of the purpose for which it was transmitted or (iii) is any other person who obtained knowledge or possession of the communication as the result of an intentional breach of the physician's duty of nondisclosure by the physician or his agent or servant and (d) the claimant is the holder of the privilege or a person authorized to claim the privilege for him.

"(3) There is no privilege under this rule as to any relevant communication between the patient and his physician (a) upon an issue of the patient's condition in an action to commit him or otherwise place him under the control of another or others because of alleged mental incompetence, or in an action in which the patient seeks to establish his competence or in an action to recover damages on account of conduct of the patient which constitutes a criminal offence other than a misdemeanor, or (b) upon an issue as to the validity of a document as a will of the patient, or (c) upon an issue between parties claiming by testate or intestate succession from a deceased patient.

"(4) There is no privilege under this rule in an action in which the condition of the patient is an element or factor of the claim or defense of the patient or of any party claiming through or under the patient or claiming as a beneficiary of the patient through a contract to which the patient is or was a party.

"(5) There is no privilege under this rule as to information which the physician or the patient is required to report to a public official or as to information required to be recorded in a public office, unless the statute requiring the report or record specifically provides that the information shall not be disclosed.

"(6) No person has a privilege under this rule if the judge finds that sufficient evidence, aside from the communication has been introduced to warrant a finding that the services of the physician were sought or obtained to enable or aid anyone to commit or to plan to commit a crime or a tort, or to escape detection or apprehension after the commission of a crime or a tort.

"(7) A privilege under this rule as to a communication is terminated if the judge finds that any person while a holder of the privilege has caused the physician or any agent or servant of the physician to testify in any action to any matter of which the physician or his agent or servant gained knowledge through the communication."

These provisions are the same as Model Code of Evidence, Rules 220–223.

95. The California privilege, for example is subject to 12 exceptions: personal injury cases, services in aid of a crime or tort, criminal proceedings, damage actions for criminal conduct of the patient, will contests, malpractice cases, disputes as to intention of patient as to writing affecting property, validity of same, commitment proceedings, restoration proceedings, certain required reports, proceedings to terminate a license or privilege. West's Ann.Cal.Evid.Code §§ 996–1007. Not much except the smile is left for the doctor.

96. N.C.G.S. § 8–53 (1969 amendment). Such a proviso was recommended for enactment by other states by Committee on the Improvement of the Law of Evidence of the American Bar Association for 1937–38. 8 Wigmore, Evidence (McNaughton rev.) § 2380a, n. 4.

See Sims v. Charlotte Liberty Mutual Ins. Co., 257 N.C. 32, 125 S.E.2d 326 (1962) where Moore, J., in a perceptive opinion observed with respect to the application of G.S. § 8–53, "It seems to us that the privilege statute, when strictly applied without the exercise of discretion on the part of the judge, is more often unjust than just . . . Our Legislature intended the statute to be a shield and not a sword. It was careful to make provision to avoid injustice and suppression of truth by putting it in the power of the trial judge to compel disclosure. Judges should not hesitate to require the disclosure where it appears to them to be necessary in order that the truth be known and justice be done. The Supreme Court cannot exercise such authority and discretion, nor can it repeal or amend the statute by judicial decree. If the spirit and purpose of the law is to be carried out, it must be at the superior court level."

The *Sims* case is noted in 41 N.C.L.Rev. 621 (1963).

with an appreciation of the need for truth and a fear of its suppression, could draw the danger of injustice from the privilege, under this provision. A judiciary with the sentimental attitude of Buller, J., would administer the mixture as before.

Third, the retention or the reestablishment of the common law practice which makes accessible to the court the facts which the physician learns from consultation and examination. More than a century of experience with the statutes has demonstrated that the privilege in the main operates not as the shield of privacy but as the protector of fraud. Consequently the abandonment of the privilege seems the best solution.[97]

97. This is the course adopted by the draftsmen of the proposed Rules of Evidence for the United States District Courts and Magistrates. Rule 504 of the proposed rules provides for a psychotherapist-patient privilege but the proposed rules contain no provision for a general physician-patient privilege. See Advisory Committee's Note, F.R. Ev. (R.D.1971) 504.

§2380a. Policy of the privilege. What is to be said in favor of such an innovation upon the common law? The privilege has been supported, in the home of its origin, in the following passages:

Commissioners on Revision of the Statutes of New York, 3 N.Y. Rev. Stat. 737 (1836): The ground on which communications to counsel are privileged, is the supposed necessity of a full knowledge of the facts, to advise correctly,

wards to give evidence of the condition of the employee at the time such examination was made," but "there shall be no other disqualification or privilege preventing the testimony of any physician or surgeon, who actually makes an examination"); Doty v. Crystal Ice & Fuel Co., 118 Kan. 323, 235 Pac. 96 (1925) (statute applied).

Michigan: Mich. Stat. Ann. §17.169 (1950) (workmen's compensation; any physician "who shall make or be present at any such examination [of a claimant] may be required to testify").

Minnesota: Minn. Stat. Ann. §176.155 (Supp. 1958) (workmen's compensation; any physician assigned by industrial commission or furnished or paid by employer may be required to testify "as to any knowledge acquired by him in the course of such treatment or examination relative to the injury or disability resulting therefrom"); id. §176.411 ("A hospital record relating to medical or surgical treatment given an employe is admissible as evidence").

Mississippi: Miss. Code Ann. §6998-08(f) (1952) (workmen's compensation; "Medical and medical [surgical?] treatment . . . shall not be deemed to be privileged").

Missouri: Mo. Ann. Stat. §287.140 (Supp. 1958) (workmen's compensation; "The testimony of any physician . . . shall be admissible . . . subject to all of the provisions of section 287.210"; records of "every hospital or other person furnishing the employee with medical aid," provable by certified copy); id. §287.210 ("The testimony of any physician who treated or examined the injured employee shall be admissible . . . but only if the medical report of such physician has been made available to all parties").

Montana: Mont. Rev. Codes Ann. §92-609 (1947) (workmen's compensation; physician may be required to testify).

Nevada: Nev. Rev. Stat. §616.355 (Supp. 1957) (Industrial Insurance Act; "Information gained by the attending physician or surgeon, while in attendance on the injured employee, shall not be considered a privileged communication").

New Mexico: N.M. Stat. Ann. §59-11-27 (1953) (Occupational Disease Act; physician required to testify), repealed by N.M. Laws 1957, c. 246, §94 and replaced by a workmen's compensation law which omits the relevant language.

North Carolina: N.C. Gen. Stat. §97-27 (1958) (like Del. Code Ann. tit. 19, §2343 (1953), *supra*).

Ohio: State ex rel. Galloway v. Industrial Commission, 134 Ohio St. 496, 17 N.E.2d 918 (1938) (under Gen. Code §1465-44 (like Ohio Rev. Code Ann. §4123.05 (Page, 1954)), authorizing Industrial Commission to make rules, no power is granted to provide for a waiver of the privilege of physician and patient as a condition precedent to filing of claim; however, the court points out the condition could be imposed by legislative enactment).

Rhode Island: R.I. Gen. Laws Ann. §28-33-37 (1956) (workmen's compensation; report of impartial medical examiner is admissible).

South Carolina: S.C. Code §72-307 (1952) (like Del. Code Ann. tit. 19, §2343 (1953), *supra*).

South Dakota: S.D. Code §64.0605 (1939) (workmen's compensation; impartial physician appointed by commissioner shall not "be prohibited from testifying").

Tennessee: Tenn. Code Ann. §50-1004 (Supp. 1958) (workmen's compensation; physician treating the employee "may be required to testify as to any knowledge acquired by him in the course of such treatment").

Virginia: Va. Code Ann. §65-88 (1950) (like Del. Code Ann. tit. 19, §2343 (1953), *supra*).

Washington: Wash. Rev. Code §51.04.050 (1958) (workmen's compensation; any physician examining a claimant may be required to testify, "and shall not be exempt from so testifying by reason of the relation of physician and patient").

Wisconsin: Wis. Stat. Ann. §102.13 (1957) ("Any physician who shall be present at any such examination may be required to testify"; also, attending physician may furnish to employee, employer, insurance carrier or commission information and reports relative to claim, and "the testimony of any physician or surgeon who is licensed to practice where he resides or practices outside the state, may be received in evidence in compensation proceedings").

Wyoming: Wyo. Comp. Stat. Ann. §72-182 (Supp. 1957) (workmen's compensation; attendant physician must testify when directed "and the law of privileged communication between physician and patient, as fixed by statute, shall not apply in such cases").

and to prepare for the proper defence or prosecution of a suit. But surely the necessity of consulting a medical adviser, when life itself may be in jeopardy, is still stronger. And unless such consultations are privileged, men will be incidentally punished by being obliged to suffer the consequences of injuries without relief from the medical art, and without conviction of any offence.] Besides, in such cases, during the struggle between legal duty on the one hand, and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will, in most cases, furnish a temptation to the perversion or concealment of truth, too strong for human resistance.

MILLER, J., in *Edington v. Mutual Life Ins. Co.*, 67 N.Y. 185, 194 (1871): It is a just and useful enactment introduced to give protection to those who were in charge of physicians from the secrets disclosed to enable them properly to prescribe for diseases of the patient. To open the door to the disclosure of secrets revealed on the sickbed, or when consulting a physician, would destroy confidence between the physician and the patient, and, it is easy to see, might tend very much to prevent the advantages and benefits which flow from this confidential relationship.]

To test these arguments, let us refer to the fundamental canons which must be satisfied by every privilege for communications (§2285 *supra*). The questions must be asked: Does the communication originate in a confidence? Is the inviolability of that confidence vital to the due attainment of the purposes of the relation of physician and patient? Is the relation one that should be fostered? Is the expected injury to the relation, through disclosure, greater than the expected benefit to justice? A negative answer to any one of these questions would leave the privilege without support. In truth, all of them, except the third, may justly be answered in the negative:]

(1) In only a few instances, out of the thousands daily occurring, is the fact communicated to a physician confidential in any real sense. Barring the facts of venereal disease and criminal abortion, there is hardly a fact in the categories of medicine in which the patient himself attempts to preserve any real secrecy.[1] Most of one's ailments are immediately disclosed and discussed. The few that are not openly visible are at least explained to intimates. No statistical reckoning is needed to prove this. These facts are well enough known.]

(2) Even where the disclosure to the physician is actually confidential, it would nonetheless be made though no privilege existed. People would not be deterred from seeking medical help because of the possibility of disclosure in court. If they would, how did they fare in the generations before the privilege came?] Is it noted in medical chronicles that, after the privilege was established in New York, the floodgates of patronage were let open upon the medical profession, and long-concealed ailments were then for the first time brought forth to receive the blessings of cure? And how is it today in those jurisdictions where no privilege exists — does

§2380a. [1] Note that some statutes — e.g., the Michigan statute cited *supra* §2380, note 5 — for urgent reasons of public health abolish the privilege for sexual disease in certain cases, even though it is there that the requirement of confidentiality is most fully satisfied.

For the authorities relating to the *psychologist-client* privilege, see §2286 *supra*, note 23.

the medical profession in two thirds of the Union enjoy, in a marked way, an afflux of confidence contrasting with the scanty revelations vouchsafed in that other third where no privilege protects? If no difference appears, then this reason for the privilege is weakened; for it is undoubted that the rule of privilege is intended (§2285 *supra*) not to subserve the party's wish for secrecy as an end in itself but merely to provide secrecy as a means of preserving the relation in question whenever without the guarantee of secrecy the party would probably abstain from fulfilling the requirements of the relation.]

(3) That the relation of physician and patient should be fostered, no one will deny.]

But (4) that the injury to that relation is greater than the injury to justice — the final canon to be satisfied — must emphatically be denied. The injury is decidedly in the contrary direction. Indeed, the facts of litigation today are such that the answer can hardly be seriously doubted]

Of the kinds of ailments that are commonly claimed as the subject of the privilege, there is seldom an instance where it is not ludicrous to suggest that the party cared at the time to preserve the knowledge of it from any person but the physician. From asthma to broken ribs, from influenza to tetanus, the facts of the disease are not only disclosable without shame, but are in fact often publicly known and knowable by everyone — by everyone except the appointed investigators of truth. The extreme of farcicality is often reached in litigation over personal injuries — in the common case, a person injured by an automobile amid a throng of sympathizing onlookers. Here the element of absurdity will sometimes be double. In the first place, there is nothing in the world, by the nature of the injury, for the physician to disclose which any person would ordinarily care to keep private from his neighbors; and, in the second place, the fact which would be most strenuously secreted and effectively protected, when the defendant called the plaintiff's physician and sought its disclosure, would be the fact that the plaintiff was not injured at all!]

The injury to justice by the repression of the facts of corporal injury and disease is much greater than any injury which might be done by disclosure. And furthermore, the few topics — such as venereal disease and abortion — upon which secrecy might be seriously desired by the patient come into litigation ordinarily in such issues (as when they constitute cause for a bill of divorce or a charge of crime) that for these very facts common sense and common justice demand that the desire for secrecy shall not be listened to.

There is but one form in which the argument for the privilege can be put with any semblance of plausibility, and in that form it commonly presents itself to the view of medical men justly jealous for the *honor of their profession*. This argument is that, since the secrets of the legal profession are allowed to be inviolable, the secrets of the medical profession have at least an equal title to consideration. This, to be sure, is no more than analogy; and nothing is more fallible than an argument from analogy. But, leaving aside the consideration that the privilege for communications to attorneys stands itself on none too firm a foundation (§2291

supra), and leaving aside the primary tests (just examined) by which every privilege must be judged, and answering the argument as it is put, the answer is that the services of an attorney are sought primarily for aid in litigation, actual or expected, while those of the physician are sought for physical cure; that hence the rendering of that legal advice would result directly and surely in the disclosure of the client's admissions if the attorney's privilege did not exist, while the physician's curative aid can be and commonly is rendered irrespective of making disclosure; and, finally, that thus the absence of the privilege would convert the attorney habitually and inevitably into a mere informer for the benefit of the opponent, while the physician, being called upon only rarely to make disclosures, is not consciously affected in his relation with the patient. The function of the two professions being entirely distinct, the moral effect upon them of the absence of the privilege is different.

The real support for the privilege seems to be mainly the weight of professional medical opinion pressing upon the legislature. And that opinion is founded on a natural repugnance to being the means of disclosure of a personal confidence. But the medical profession should reflect that the principal issues in which justice asks for such disclosure are those – personal injury and life and accident insurance – which the patient himself has *voluntarily brought into court*. Hence the physician has no reason to reproach himself with the consequences which justice requires.

It is certain that the practical employment of the privilege has come to mean little but the suppression of useful truth – truth which ought to be disclosed and would never be suppressed for the sake of any inherent repugnancy in the medical facts involved. Ninety-nine per cent of the litigation in which the privilege is invoked consists of three classes of cases – actions on policies of life insurance where the deceased's misrepresentations of his health are involved, actions for corporal injuries where the extent of the plaintiff's injury is at issue, and testamentary actions where the testator's mental capacity is disputed. In all of these the medical testimony is absolutely needed for the purpose of learning the truth. In none of them is there any reason for the party to conceal the facts, except as a tactical maneuver in litigation. In the first two of these, the advancement of fraudulent claims is notoriously common; nor do the culpable methods of some insurers or carriers, whatever they may have been or still are, justify the infliction of retaliatory penalties, indirectly and indiscriminately, by means of an unsound rule for the suppression of truth.[3] In none of these cases need there be any fear that the absence of the privilege will subjectively hinder people from consulting physicians freely. The actually injured person would still seek medical aid, the honest in-

[3] See the comment of Earl, J., in Renihan v. Dennin, 103 N.Y. 573, 580, 9 N.E. 320, 322 (1886); Nelson v. Ackermann, 249 Minn. 582, 591, 83 N.W.2d 500, 506 (1957); cf., Thomas v. Maryland Cas. Co., 32 So.2d 472 (La. Ct. App. 1947) (workmen's compensation; plaintiff's exercise of privilege held to raise presumption that doctor's testimony would have been adverse; see §287 *supra*).

Several of the statutes quoted *supra* §2380, note 5, abrogate the patient's privilege in actions for personal injury.

sured would still submit to medical examination, and the testator would still summon physicians to his cure.

There is little to be said in favor of the privilege, and a great deal to be said against it.[3] The adoption of it in any other jurisdictions is earnestly to be deprecated.

A moderate improvement in the present law — where the privilege exists — would be to adopt the North Carolina and Virginia rule, which allows the court to require disclosure where necessary.[4]]

[3] A discussion of the scope and policy of the privilege will also be found in the following: Chafee, Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand? 52 Yale L.J. 607 (1943); Long, Physician-Patient Privilege Statutes Obstruct Justice, 25 Ins. Counsel J. 224 (1958); Peterson, Patient-Physician Privilege in Missouri, 20 U. Kan. City L. Rev. 122 (1952); Sanborn, Physician's Privilege in Wisconsin, 1 Wis. L. Rev. 141 (1921); Note, Discovery and the Physician-Patient Privilege, 34 Neb. L. Rev. 507 (1955); Note, 47 Nw. U.L. Rev. 384 (1952), reprinted in Selected Writings on the Law of Evidence and Trial 254-259 (Fryer ed. 1957) (psychiatrist and patient); Comment, The Physician-Patient Privilege in Louisiana and Its Limitations, 31 Tul. L. Rev. 192 (1956); Note, The Physician-Patient Privilege, 58 W. Va. L. Rev. 76 (1955).

[4] See the North Carolina and Virginia statutes cited *supra* §2380, note 5. In 1937-38 the ABA's Committee on the Improvement of the Law of Evidence, after making findings consistent with the text of this section, reported as follows: "We do not here recommend the abolition of the privilege, but we do make the following recommendation: The North Carolina statute allows a wholesome flexibility. . . . This statute has needed but rare interpretation. It enables the privilege to be suspended when suppression of a fraud might otherwise be aided. We recommend the enactment of the North Carolina proviso." However, neither the Model Code of Evidence Rules 220-223 (1942), nor Uniform Rule of Evidence 27 (approved in 1953 and quoted *supra* §2380, note 5) allows the judge discretion. On the other hand, both of these codifications, in their comments, express doubts as to the wisdom of the privilege.]

PRIVILEGED COMMUNICATIONS: IS JUSTICE SERVED OR OBSTRUCTED BY CLOSING THE DOCTOR'S MOUTH ON THE WITNESS STAND?

By ZECHARIAH CHAFEE, JR.†

PHYSICIANS and surgeons are required by the ethics of their profession to preserve the secrets of their patients which have been communicated to them or learned from the inspection of symptoms and other bodily conditions. How far this ethical requirement should be enforced by law is a question on which there is much difference of opinion among both lawyers and doctors.[1]

No state has made disclosure of confidence a crime, but in some the license to practice may be revoked for this cause. Seventeen states still seem to preserve the view of the English common law that there is no legal check upon the revelation of medical secrets. On the witness stand, at all events, a doctor in these states must tell all he knows.[2] The remaining states adopt a half-way attitude towards the obligation of secrecy, of which the New York statute is typical.[3] Unless the patient consents, the doctor is not allowed, while testifying in court, "to disclose any information which he acquired in attending a patient in a professional capacity and which was necessary to enable him to act in that capacity." Thus there is no liability to the patient if the doctor tells every last detail in clubroom gossip or in the thickly veiled items of a medical journal, but he is prohibited from divulgi ıg any of the truth in the place where it is usually most stringently required—the witness stand. Some of these statutes make exceptions ; ɔr special medical situations where disclosure is badly needed, like abortion.[4] And several of the states recognizing the

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1. For a classic discussion of this problem, see 8 WIGMORE, EVIDENCE (3d ed. 1940) §§ 2380-91. See also (1921) 152 L. T. 53 (debates at British Medical Association); (1922) 153 L. T. 228, 252 (debates at British Medico-Legal Society); (1937) 83 L. J. 320 (debates in House of Commons).

2. These states are Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Rhode Island, South Carolina, Tennessee, Texas, Ve-mont, and Virginia.

3. This statute was first enacted in 1828. See N. Y. CIVIL PRACTICE ACT (1920) §§ 352, 354, as subsequently amended.

4. 8 WIGMORE, EVIDENCE, § 2380, n. 5, gives full references to the state statutes. The ensuing list mentions only the date of the original enactment without regard to subsequent amendments. The statutes vary in their terms, particularly as to waiver of the privilege. The ensuing list mentions only variations of especial medical interest, including the fact of adoption of the Uniform Narcotic Drug Act (U. N. D. A.): Alaska (1913) (except for insanity); Arizona (1913) (U. N. D. A.); Arkansas (1919); Cali-

doctor-patient privilege in general have adopted the Uniform Narcotic Drug Act, which provides that "information communicated to a physician in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug, shall not be deemed a privileged communication." [5]

Although the general policy of the law is to obtain as many facts as possible about a controversy on trial, rules of evidence often exclude reliable testimony if it was acquired by the witness through some confidential relation. A husband would hesitate to tell his wife about damaging facts and the thorough intimacy of marriage would be turned into watchful suspicion and reticence, if the law did not refuse to make her the means of his undoing.[6] Likewise a man might not consult an honest lawyer, or if he did, would tend to keep back from him anything that looked unfavorable to the case, if the lawyer could be made the leading witness against him and forced to reveal all that was told him by his client. So the lawyer cannot speak without his client's consent.[7] In many states a statute protects the secrets of the confessional; [8] and even without such legislation few lawyers would have the hardihood to ask that a priest who keeps silent should be imprisoned for contempt of court.

Some doctors may feel that it is an unfair discrimination against their profession if lawyers' secrets are protected from disclosure in court

fornia (1872) (except for mental condition and venereal disease); Canal Zone (1934); Colorado (1921); District of Columbia (1919) (U. N. D. A.); Georgia (1935); Hawaii (1925) (U. N. D. A.); Idaho (1919); Indiana (1926); Iowa (1897) (U. N. D. A.); Kansas (1923); Kentucky (1915); Louisiana (1928); Maryland (1935) (U. N. D. A.); Michigan (1915) (except for illegal marriage of persons sexually diseased); Minnesota (1913) (except for bastardy); Mississippi (1906); Missouri (1919) (except for abortion); Montana (1935) (U. N. D. A.); Nebraska (1922) (U. N. D. A.); Nevada (1912) (U. N. D. A.); New Mexico (1929) (U. N. D. A.); New York (1828) (except for narcotic investigations); North Carolina (1919) (allows presiding judge of superior court to compel disclosure when necessary to administration of justice, U. N. D. A.); North Dakota (1913); Ohio (1921) (U. N. D. A.); Oklahoma (1931) (U. N. D. A.); Oregon (1920) (U. N. D. A.); Pennsylvania (1895); Philippine Islands (1901); Puerto Rico (1911) (except for malpractice, U. N. D. A.); South Carolina (1934) (U. N. D. A.); South Dakota (1919) (U. N. D. A.); Utah (1917) (U. N. D. A.); Virgin Islands (1920); Washington (1909); West Virginia (1897) (U. N. D. A.); Wisconsin (1919) (except for lunacy and malpractice, U. N. D. A.); Wyoming (1920) (U. N. D. A.).

5. Uniform Narcotic Drug Act, § 17, ¶ 2. This statute has been adopted in the following states and territories, of which those starred in the list do not recognize a general doctor-patient privilege: Arizona, District of Columbia, Hawaii, Iowa, Maryland,* Montana, Nebraska, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Puerto Rico, South Carolina,* South Dakota, Tennessee,* Texas,* Vermont, West Virginia, Wisconsin, Wyoming.

6. See 8 WIGMORE, EVIDENCE, §§ 2332-41.

7. *Id.* §§ 2290-2329. Full arguments for and against this privilege are given in § 2291.

8. *Id.* §§ 2394-96.

and yet physicians' secrets must be laid bare. Perhaps lawyers as well as doctors should be forced to divulge information when the judge thinks disclosure essential to the public interest, and proposals are now under consideration for extensive modifications of the attorney-and-client privilege.[9] However, the success or failure of these proposals ought not to affect the question whether medical secrets should be inviolable in court. The relation between lawyer and client does differ materially from the relation between doctor and patient, and each privilege should be judged on its own merits. The administration of justice ought not to be shaped by inter-professional jealousies and trivial claims to prestige. Instead, we can all agree that it is a misfortune when a lawsuit is won by the party who would lose it if all the facts were known, and that we increase the risk of such a miscarriage of justice whenever we allow an important witness to keep any helpful facts away from the judge and jury. Secrecy in court is prima facie calamitous, and it is permissible only when we are very sure that frankness will do more harm than good. With doctors' secrets as with any other kind of secrets, the only proper test is the welfare of the community. Courtroom secrecy in the particular case must produce a public good which more than offsets the risks resulting from the concealment of truth and from the lies which can be made with less fear of detection. If the doctor-patient privilege should prove to be socially undesirable, doctors, possessing a high professional sense of public welfare, should be among the first to oppose it.

The reasons usually advanced for extending the privilege of silence to the medical profession are not wholly satisfactory. First, it is said that if the patient knows tha. his confidences may be divulged in future litigation he will hesitate in many cases to get needed medical aid. But although the man who cons its a lawyer usually has litigation in mind,, men very rarely go to a doctor with any such thought. And even if they did, medical treatment is so valuable that few would lose it to prevent facts from coming to light in court. Indeed, it may be doubted whether, except for a small range of disgraceful or peculiarly private matters, patients worry much about having a doctor keep their private affairs concealed from the world. This whole argument that the privilege is necessary to induce persons to see a doctor sounds like a philosopher's speculation on how men may logically be expected to behave rather than the result of observation of the way men actually behave. Not a single New England state allows the doctor to keep silent on the witness stand. Is there evidence that any ill or injured person in New England has ever stayed from a doctor's office on that account?

The same a priori quality vitiates a second argument concerning the evils of compelling medical testimony, namely, that a strong sense of

9. See Morgan, *Suggested Remedy for Obstructions to Expert Testimony by Rules of Evidence* (1943) 10 U. of Chi. L. Rev. 285.

professional honor will prompt perversion or concealment of the truth. Has any member of the numerous medical societies in New England observed such a tendency among New England doctors to commit perjury for the sake of "professional honor"? In reality, there is far more danger of perjury if the physician cannot testify, only it will be perjury by the patient. In many states where the privilege exists, an unscrupulous plaintiff in an accident case can exaggerate the injury without fear of contradiction by the doctor whom he consulted right after the accident. The patient can tell the sad story of his injuries to judge, jury, and spectators, and then he can object that it would violate his bodily privacy if the doctor were allowed to take the stand and testify that the accident had left no traces one hour after it occurred. Fortunately, there is some limit to this absurdity, for most courts hold that if the patient goes into the details of his injuries, he has waived his privilege and has thrown open the whole question of his bodily conditions.[10] Otherwise he could make the statute both a sword and a shield. But even this rule about waiver does not promote truth-telling any too well. The patient may tell some rather big lies about his health without "going into details," and the courts are by no means clear in defining the point where details begin. There is also abundant confusion on the question whether what the patient says under cross-examination opens the door for his doctor to testify. Some courts hold that cross-examination is not a waiver like direct testimony, because the patient does not now speak willingly. By this view, the opposing lawyer who ventures to ask the patient any questions may find the witness going into the most intimate details without regard to either privacy or truth, and yet the lawyer will be helpless to contradict this highly colored story by calling the physician.[11]

Another argument for the privilege is that employees are often treated after accidents by physicians who are in charge of the company hospital or otherwise dependent upon the good will of the employing corporation. It was urged to legislatures that some of these physicians were taking ad-

10. The cases are collected in Note (1938) 114 A. L. R. 798. See also 8 WIGMORE, EVIDENCE, § 2389.

11. The absurdity of this solicitude for the patient's privacy is illustrated by Harpman v. Devine, 133 Ohio St. 1, 10 N. E. (2d) 776 (1937), 11 U. OF CIN. L. REV. 544. The plaintiff sued the owner of a building for heavy damages, charging that the defendant negligently suspended a fire hose from the building in such a manner that a violent wind caused the hose to break a window, knocking glass against the plaintiff. He testified that since this accident he had suffered loss of weight, severe and chronic headaches, failing eyesight, insomnia, facial paralysis, and inability to walk normally; but that before the glass hit him his general condition was "very good." On cross-examination he admitted that he had consulted various physicians before the accident. The defendant called one of these doctors for the purpose of showing that the plaintiff was suffering from anemia before the accident, but the court refused to allow the doctor's evidence "in view of the very delicate and confidential nature of the relation."

vantage of their position to obtain from the patients information which would tend to defeat a claim for damages. This argument has the merit of not being abstract, but of asserting a basis in fact. Yet even if it is valid, it might be wiser to admit the evidence of the physicians, trusting in the jury to discount it heavily if an improper attitude towards the patients exists.

Where the statutory privilege is in force, what is its scope? In the first place, what sort of medical person is included?[12] Any licensed physician or surgeon falls within the statute, and this applies to hospital physicians though they are not specifically selected by the patient.[13] There is no privilege for communications to unlicensed practitioners. Thus mental healers, chiropractors and osteopaths can be forced to disclose communications from their patients, unless perhaps their professional status is expressly recognized by law. Nor does the privilege apply to an unlicensed "orthopedist" who is teaching gymnastic exercises taken by medical advice.[14] And those psychoanalysts who have been too busy to study medicine must have spicier facts to relate than physicians, but no court has yet bound them to secrecy. How about the numerous assistants who surround doctors under modern conditions? Many attempts have been made to prevent nurses from telling about their patients, but these have usually failed.[15] Most courts say that if public policy demands the extension of the privilege to nurses and other hospital attendants, then the change in the law should be made by the legislature, not by judicial action. Here is an enticing invitation to organizations of nurses to increase their professional prestige by lobbying for a statutory amendment which will put them on the same high level of secrecy as doctors, a result which has already been accomplished in New York and a few other states. Dentists, druggists and veterinaries [16] may also resent being left out in the cold.

No end of trouble has arisen about the admissibility of medical records. If a doctor cannot tell the court what he saw, then the hospital records in which he wrote down what he saw seem logically just as unavailable. Yet some courts are impressed by the fact that the law requires such rec-

12. The cases are collected in Note (1930) 68 A. L. R. 176; 8 WIGMORE, EVIDENCE, § 2382.

13. The cases are collected in Note (1923) 22 A. L. R. 1217; (1938) 72 U. S. LAW REV. 619.

14. See Laurie Co. v. McCullough, 174 Ind. 477, 92 N. E. 337 (1910).

15. The cases are collected in Notes (1925) 39 A. L. R. 1421, (1930) 68 A. L. R. 176. On hospital attendants, see (1938) 22 MARQ. L. REV. 211.

16. The status of veterinaries was raised in Hendershot v. Western Union Telegram Co., 106 Iowa 529, 76 N. W. 828 (1898), a suit brought by the owner of a race horse against the Western Union for delay in transmitting a telegram, "Bravo is sick; come at once." The doctor arrived at last, but Bravo died. The Western Union lawyer asked the doctor what the owner said to him about Bravo's symptoms. The owner urged that the communications from him to the veterinary were privileged, but the court held that veterinaries were not covered by the statute.

ords to be kept, and see little sense in this if they cannot be used for the sake of attaining justice.[17] For example, it would be absurd if the records of a state hospital for the insane could not be consulted in a will contest for their bearing on the mental capacity of the testator.[18] So judges have been inclined to read a wide exception into the statute to cover such situations. Thus death certificates ought to be admissible.[19] In New York this exception has also been extended to public health records, which were admitted to show that the defendant was a typhoid carrier who had been warned not to participate in the service of food. The records were used to establish her liability in damages to the estate of a man who died of typhoid after eating food which had passed through her hands.[20]

Autopsies add further confusion. It is generally held that if the doctor did not attend the person during his lifetime, then the doctor can testify about performing an autopsy because the relation of the physician and patient did not exist.[21] "A deceased body is not a patient."[22] For example, a man who carried heavy accident insurance became suddenly ill, and the physician who was called removed him to a hospital and there continued to treat him until his death. The hospital pathologist was then summoned to perform an autopsy, which showed that the man died from the effect of wood alcohol in home-made gin. Although the first doctor was merely allowed to give his opinion that wood alcohol in gin was capable of causing the death, the second doctor was permitted to give all the details discovered during the autopsy.[23] Yet another court, regarding this device of evading the statutory privilege by switching doctors as an arrant subterfuge, concluded that a physician performing an autopsy "steps into the shoes of the attending physician, and must be treated as if he were the assistant of the attending physician, holding the autopsy at the direction of the latter, and that the information acquired by him through the autopsy is privileged." [24]

The requirement tha' the physician's knowledge about the patient be received in a professiona. relation raises great difficulties. Not everything medical that a doctor sees or hears is privileged. For example, if called to a house to see one person, the doctor can sometimes tell what he inciden-

17. The cases are collected in Notes (1931) 75 A. L. R. 378, (1939) 120 A. L. R. 1124.

18. See Liske v. Liske, 135 N. Y. Supp. 176 (N. Y. Sup. Ct. 1912).

19. Yet some courts exclude them. See the authorities in 8 WIGMORE, EVIDENCE, § 2385a; Notes (1922) 17 A. L. R. 359, (1926) 42 A. L. R. 1454, (1935) 96 A. L. R. 324.

20. Thomas v. Morris, 286 N. Y. 266, 36 N. E. (2d) 141 (1941), 136 A. L. R. 856.

21. The cases are collected in Note (1929) 58 A. L. R. 1134; 35 LAW NOTES 87 (N. Y. 1931).

22. Travelers' Ins. Co. v. Bergeron, 25 F. (2d) 680 (C. C. A. 8th, 1928).

23. *Ibid.*

24. Mathews v. Rex Health & Accident Ins. Co., 86 Ind. App. 335, 157 N. E. 467 (1927).

tally observed as to the health of other members of the family.[25] Though it would seem that symptoms which were obvious to every one without medical inspection cannot be said to be disclosed in confidence, several cases have forbidden hospital doctors to testify that when a man was brought in they smelled liquor on his breath or observed other common symptoms of intoxication.[26] If the patient voluntarily employs the physician, the privilege is clear. But suppose the doctor renders first aid to an unconscious man. No confidence is reposed, but the doctor does attend him in a "professional capacity." In a New York case a physician was called by a hotel to attend a guest without the latter's knowledge. The man said he had taken poison, but cursed the doctor and refused to have anything to do with him, although the doctor administered a hypodermic. The hotel guest was held to be a patient, although he did not want to be, and the doctor was forbidden to tell about the poison in order to show that the patient had forfeited his life insurance by committing suicide.[27]

Even though a professional relation exists, only information necessary to enable the doctor to act in that capacity is privileged. Matters which are entirely distinct from medical facts may be disclosed,[28] such as the patient's remarks about his will. An Indiana doctor was called to attend a sick wife and also cast a professional eye on her husband. While leaving the house, he heard the husband say, "I will get her yet, damn her; I will get her yet." Shortly afterwards the wife shot her husband. When tried for murder, she called the doctor as a witness to support her story that she killed her husband in self-defense while he was approaching her with an open knife in his hand. The trial court excluded the doctor's evidence on the ground that he was in the house in the capacity of a physician; the jury disbelieved the wife's story, and she was convicted of manslaughter. The upper court reversed, however, holding that the doctor should have been allowed to testify about threats of death though not about health.[29]

Often the illness and another fact are closely connected, as in a New York divorce trial where a physician was asked to disclose a communication from the misguided wife as to the paternity of an expected child. The referee excluded this communication, because it must have been given as a sequel to the wife's disclosure of her pregnancy, which was clearly privileged and could not be repeated. On the other hand, a California doctor was allowed to testify that while he was delivering an illegitimate child a certain man was present and admitted that he was the father.[30]

25. See Jennings v. Supreme Council, 81 App. Div. 76, 81 N. Y. Supp. 90 (1st Dep't 1903); Nichols v. State, 109 Neb. 335, 191 N. W. 333 (1922).

26. The cases are collected in Note (1932) 79 A. L. R. 1131.

27. Meyer v. Knights of Pythias, 178 N. Y. 63, 70 N. E. 111 (1904).

28. The cases are collected in 8 WIGMORE, EVIDENCE, § 2383; Note (1923) 24 A. L. R. 1202; (1938) 13 WASH. L. REV. 141.

29. Myers v. State, 192 Ind. 542, 137 N. E. 547 (1922).

30. *In re* Baird's Estate, 173 Cal. 617, 160 Pac. 1078 (1916).

A similar question arises when the victim of an accident describing his symptoms to a physician throws in occasional statements about the way he was hurt. But it seems clear that the speed of the trolley car which hit him has no more bearing on the application of surgical dressings than the legitimacy of an expected child has on the medicines or other pre-natal care which should be given to the mother.[31]

Logically it may be that the facts leading up to a physical condition are often not necessary to enable the physician to act in a professional capacity and consequently are not protected by the statute. Yet practically it is very unjust to a patient if his conversations with the physician can be sifted out by the law into two classes of utterances of which only one class is kept secret. What sort of confidence is secured by the statute if a sick and perhaps hysterical patient must be constantly on the alert, every time a question is asked him, to determine at his peril whether it is necessary for treatment, and, even if it is, must be watchful lest he add something to his answer which is not necessary? If the privilege is to exist at all, the law might well take the position that all the communications of the patient which are actuated by his feeling of confidence in his medical adviser and which he would naturally make in furnishing the doctor with information as a basis of treatment are entitled to secrecy, even though some of these facts if wrenched from the conversation and taken singly have no medical value. A patient should not be forced to tell his story to the doctor with the circumspection of a lawyer drawing pleadings.

The privilege belongs to the patient and not to the physician. Hence the patient cannot be forced to testify about the consultation any more than can the doctor. Conversely, if the patient consents to the disclosure, the doctor can no longer insist on remaining silent. The effectiveness of anything less than express consent, however, raises a perplexing issue.[32] Suppose, for example, the plaintiff in a personal injury case, who has been to several doctors, calls only one physician who is favorable to his own claim. There is great confusion as to whether the plaintiff can still insist that it might cause him "embarrassment and disgrace" if the defense were allowed to put on his other doctors who are ready to tell a very different story about the plaintiff's bodily condition.[33]

If the patient is dead and can no longer waive his privilege, must the doctor's lips then be sealed forever? Some statutes have neglected to provide for this emergency, while others expressly permit the executor or administrator of the patient to authorize the doctor to speak.[34] Yet no

31. If the doctor were a psychiatrist, who was curing her of melancholia or some other mental or nervous disorder, questions on such a fact would be highly important.

32. The effect of the patient's testifying about his own health has already been discussed. See p. 610 *supra*.

33. See Comment (1922) 31 YALE L. J. 529; Notes (1929) 62 A. L. R. 680, (1934) 90 A. L. R. 646; (1938) 51 HARV. L. REV. 931.

34. The cases are collected in Notes (1924) 31 A. L. R. 167, (1940) 126 A. L. R. 380; 8 WIGMORE, EVIDENCE, § 2391.

matter how carefully the statute is drawn, it may fail to specify some person connected with the decedent who has an excellent reason for desiring the doctor's testimony. For example, in a Wisconsin case a widow suing as a beneficiary under an accident insurance policy was unable to prove that her husband's death was accidental except by the testimony of the physician who attended him. The Wisconsin statute did not say that a beneficiary could waive the privilege; the court forced the doctor to keep silent, and the widow recovered nothing on the policy.[35] Here the privilege, which is supposed to exist for the patient's benefit, operated to defeat one of his dearest desires. Wigmore's view that nobody except the patient may take advantage of the privilege would have accomplished a just result in this case. Certainly a person directly antagonistic to the patient should not profit from the privilege.[36]

The possibility that the patient's death silences the doctor is particularly objectionable when the patient was murdered. It may be very important to have a physician disclose the physical condition of the victim during the interval between the crime and the death. Sometimes a man kills a woman to get her out of the way because she is expecting a child, and medical testimony is necessary to establish his motive. Judges usually obviate this difficulty by saying that criminal cases are not within the spirit of the statute, although some courts refuse to carve out such an exception.[37] Usually the desired testimony relates to the bodily condition of the victim, but it may conceivably concern that of the accused and here the bars have been higher.[38] Suppose a murder on a dark street. A policeman testifies that he could not recognize the killer, but that he shot at him as he was running away and hit him in the left arm. The prosecution calls a physician for the purpose of having him testify that one hour after the murder the accused called at his office and was treated for a bullet-wound in his left arm. The accused objects on the ground that he does not want to disclose his ailments to the public. It is by no means certain on the authorities that the doctor would be allowed to testify, and so the prisoner might be acquitted for inability to identify him as the murderer.[39]

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35. Maine v. Maryland Casualty Co., 172 Wis. 350, 178 N. W. 749 (1920) (two judges dissenting); Note (1921) 15 A. L. R. 1544.

36. Many insurance policies endeavor to avoid such difficulties by a clause in which the insured waives the privilege in advance. Such a clause is usually held valid, but it has no effect in New York. The cases are collected in Note (1928) 54 A. L. R. 412; 1 WIGMORE, EVIDENCE, § 7a.

37. The cases are collected in Note (1926) 45 A. L. R. 1357; 8 WIGMORE, EVIDENCE, § 2385.

38. See People v. Murphy, 101 N. Y. 126, 4 N. E. 326 (1885).

39. A similar but much more perplexing conflict of loyalties was presented to Dr. C. E. May of Minnesota. While Dillinger, the former Public Enemy No. 1, was fleeing from prison, he went to Dr. May to be treated for gunshot wounds incurred during his escape. Was Dr. May ethically bound as a physician to preserve secrecy or was he under a duty as a citizen to notify the police? In fact he neglected to inform the police of his ministrations and was consequently imprisoned two years for harboring a fugitive wanted

The Code of Evidence recently published by the American Law Institute[40] was originally drawn without any privilege for medical secrets in court.[41] At the last minute lawyers from states which have the privilege in their statutes forced the draftsmen of the Code to insert three new sections (§§ 221-223) establishing the physician-patient privilege. Fortunately, numerous limitations are specified which will prevent a repetition of many of the miscarriages of justice already described above. It may be argued in defense of the Code that these limitations greatly improve the law in states where the privilege now exists. Nevertheless, the American Law Institute might better have adopted a complete reform. In the first place, no matter how numerous and careful the limitations, some new situation is bound to arise where secrecy ought not to be maintained; yet the Code will prevent disclosure because the draftsmen in 1942 could not foresee this situation and so failed to insert any limitation to take care of it. Secondly, although the Code will help make the law better in states which now have the privilege, it will help make the law worse in states which have hitherto let in the truth. The powerful influence of the American Law Institute is likely ultimately to cause the general adoption of the Code in all the states, including those which now reject the doctor-patient privilege. Thus truth will be curtailed in regions where it is now available without any apparent corresponding gain of medical care. In Massachusetts, for instance, the doctor is now protected by the trial judge against needless disclosures, but told to speak out when truth is important. If Massachusetts should enact the Code of Evidence, many hours and many dollars would be spent on the intricacies of this new privilege[42] and sooner or later some badly needed testimony would be lost. But what would health gain? Does anybody seri usly believe that the Massachusetts General Hospital or the Boston Lying-In Hospital would suddenly rise to new heights of excellence becau : patients could throng to them assured that if they should ever get into litigation a few of their medical secrets would occasionally be hidden from the prying curiosity of judges and jurors?

While the law has been so solicitous about the doctor's duty to keep silent on the witness-stand, it has done little to protect the patient's medical secrets from disclosure to the world in general. No statute requires

under a federal warrant. The *Lancet* commented that "colleagues in every country will applaud his action in not betraying a professional trust." (1934) 226 LANCET 1183. Not many laymen are likely to join in the applause.

40. See Morgan, *loc. cit. supra* note 9.

41. See RESTATEMENT, EVIDENCE (Proposed Final Draft, March 16, 1942, submitted to the Annual Meeting, May, 1942).

42. The New York doctor-patient statute (CIVIL PRACTICE ACT § 352) is twelve lines long, and it takes eight pages of small type just to summarize briefly the judicial decisions interpreting these lines. See 3B GILBERT-BLISS, CIVIL PRACTICE OF NEW YORK ANN. (1942) 180-87.

the doctor to pay damages to his patient. At common law, untruthful statements by the doctor may constitute actionable defamation,[43] but if he tells the truth in breach of confidence it is very doubtful whether he incurs any contractual liability. Recovery was denied the patient in the only case in point, *Simonsen v. Swensen*.[44] A guest of a small hotel in a Nebraska town consulted a doctor who diagnosed his ailment as syphilis. He told the patient of the danger of communication and got his promise to leave the hotel the next day. On that day the doctor made a professional call on the owner of the hotel, and on finding that the patient had not moved out he warned the owner that the man had "a contagious disease." The patient was forced to leave the hotel, and sued the doctor for disclosing medical secrets. The Nebraska court thought that a doctor ought to pay damages for telling the truth in breach of the confidential relation to his patient, but that he should have the same right as a man who is sued for slander to insist that he acted under a duty to make the disclosure, which was more important than the duty to keep silent. Clearly his statutory obligation to make health reports would justify breaches of confidence therein. Here, however, he was under no legal obligation to divulge his patient's disease; but the court decided that in view of the great danger to life resulting from silence he had a moral obligation to speak which overrode his duty of secrecy. Consequently, the patient lost his case.

Much can be said for and against this result. One commentator says that the Nebraska case "stands for the triumph of medical altruism over legal duty."[45] Certainly, disclosure of risks of infection is very desirable; but it would be wiser to require all contagious diseases to be reported to a public official, who should have power to take all steps necessary to protect people from the patient, whether this required publicity or his removal to a hospital. There are obvious dangers in leaving it to every physician to determine whether circumstances justify him in betraying intimate confidences to the lay public.

Legislatures and courts have been occupied for over a century in closing the physician's mouth in the very place where the truth is badly needed. And yet the much more important obligation of his silence in private life has hardly been considered. In the few instances where honest patients do dread disclosure of their physical condition by a doctor, their fear is not that the truth may some day be forced from him in court, but that he may voluntarily spread the facts among his friends and theirs in conversation. Yet against this really dangerous possibility the statutes and courts give almost no protection.

43. See Smith v. Driscoll, 94 Wash. 441, 162 Pac. 572 (1917).

44. 104 Neb. 224, 177 N. W. 831 (1920), 9 A. L. R. 1254, (1921) 30 YALE L. J. 289, (1920) 20 COL. L. REV. 890, (1921) 34 HARV. L. REV. 312, (1920) 75 J. AM. MED. ASS'N 1207.

45. (1921) 34 HARV. L. REV. 312, 314.

Advisory Committee's Note

The rules contain no provision for a general physician-patient privilege. While many states have by statute created the privilege, the exceptions which have been found necessary in order to obtain information required by the public interest or to avoid fraud are so numerous as to leave little if any basis for the privilege. Among the exclusions from the statutory privilege, the following may be enumerated; communications not made for purposes of diagnosis and treatment; commitment and restoration proceedings; issues as to wills or otherwise between parties claiming by succession from the patient; actions on insurance policies; required reports (venereal diseases, gunshot wounds, child abuse); communications in furtherance of crime or fraud; mental or physical condition put in issue by patient (personal injury cases); malpractice actions; and some or all criminal prosecutions. California, for example, excepts cases in which the patient puts his condition in issue, all criminal proceedings, will and similar contests, malpractice cases, and disciplinary proceedings, as well as certain other situations, thus leaving virtually nothing covered by the privilege. California Evidence Code §§ 990-1007. For other illustrative statutes see Ill.Rev.Stat.1967, c. 51, § 5.1; N.Y.C.P.L.R. § 4504; N.C.Gen.Stat.1953, § 8-53. Moreover, the possibility of compelling gratuitous disclosure by the physician is foreclosed by his standing to raise the question of relevancy. See Note on "Official Information" Privilege following Rule 509, *infra*.

The doubts attendant upon the general physician-patient privilege are not present when the relationship is that of psychotherapist and patient. While the common law recognized no general physician-patient privilege, it had indicated a disposition to recognize a psychotherapist-patient privilege; Note, Confidential Communications to a Psychotherapist: A New Testimonial Privilege, 47 Nw.U.L.Rev. 384 (1952), when legislatures began moving into the field.

The case for the privilege is convincingly stated in Report No. 45, Group for the Advancement of Psychiatry 92 (1960):

"Among physicians, the psychiatrist has a special need to maintain confidentiality. His capacity to help his patients is completely dependent upon their willingness and ability to talk freely. This makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality and, indeed, privileged communication. Where there may be exceptions to this general rule . . . ., there is wide agreement that confidentiality is a sine qua non for successful psychiatric treatment. The relationship may well be likened to that of the priest-penitent or the lawyer-client. Psychiatrists not only explore the very depths of their patients' conscious, but their unconscious feelings and attitudes as well. Therapeutic effectiveness necessitates going beyond a patient's awareness and, in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment."

A much more extended exposition of the case for the privilege is made in Slovenko, Psychiatry and a Second Look at the Medical Privilege, 6 Wayne L.Rev. 175, 184 (1960), quoted extensively in the careful Tentative Recommendation and Study Relating to the Uniform Rules of Evidence (Article V. Privileges), Cal.Law Rev. Comm'n, 417 (1964). The conclusion is reached that Wigmore's four conditions needed to justify the existence of a privilege are amply satisfied.

Illustrative statutes are Cal.Evidence Code §§ 1010-1026; Ga.Code § 38-418 (1961 Supp.); Conn.Gen.Stat., § 52-146a (1966 Supp.); Ill.Rev.Stat.1967, c. 51, § 5.2.