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# Behind Closed Doors: The Confidentiality of Psychotherapeutic Records in Medicaid Fraud Investigations

## I. Introduction

### A. *The Medicaid Program*

The Federal Medicaid Program was created through congressional enactment of Title XIX of the Social Security Amendments of 1965.<sup>1</sup> It was designed to expand existing social welfare programs by providing federal funds to assist individuals "whose income and resources are insufficient to meet the costs of necessary medical services . . . ."<sup>2</sup> The program, funded jointly by the state and federal governments, is administered solely by the states in accordance with guidelines established by the Department of Health, Education and Welfare.<sup>3</sup>

While the goal of furnishing the poor with greater access to health care services has been generally met,<sup>4</sup> the Medicaid pro-

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1. Social Security Amendments of 1965, ch. 531, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (1982 & Supp. III 1985)).

2. Social Security Amendments of 1965, ch. 531, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (1982 & Supp. III 1985)). The Social Security Amendments of 1965 replaced the Kerr-Mills Act of 1960, 74 Stat. 924 (repealed 1965), which neither protected persons under age 65 nor mandated the provision of any specific medical services. In addition, many states did not participate in the Kerr-Mills program and most of those that did participate had only limited programs. See Comment, *Furor Over Medicaid*, 3 COLUM. J.L. & SOC. PROBS. 158, 161 (1967).

3. Codified at 42 U.S.C. § 1396 (1982 & Supp. III 1985), 42 C.F.R. §§ 430.0 to 456.657 (1985). The Department of Health, Education and Welfare (HEW), formerly known as the Federal Security Agency, was established in 1939. In 1979, when the Office of Education became a new and separate entity, HEW was renamed the Department of Health and Human Services (HHS). As the second-largest federal department (after the Department of Defense), HHS is responsible for the administration of over 300 federal health and human service programs including the Social Security Administration which controls the Medicaid program.

4. It has been suggested that the enactment of Medicaid has contributed to the "effective collapse of major barriers to access" to health services for low income persons. See Cohen, *Medicare, Medicaid: 10 Lessons Learned*, 59 HOSPITALS 44 (1985). But see Friedman, *Indigent Care: Where the Marketplace Fails*, 59 HOSPITALS 48 (1985) (noting that Medicaid covers only between 38-46% of the population near or below the federally

gram itself is "riddled with provider fraud" and abuse.<sup>5</sup> This speculation by providers of medical services, coupled with program inefficiency and inflationary pressures, has resulted in a state of fiscal crisis within the Medicaid program<sup>6</sup> and a nationwide demand for cost constraint.<sup>7</sup>

Title XIX attempted to avert abuse of the Medicaid program through statutory provisions requiring providers of Medicaid services to maintain and produce upon demand medical records relating to services for which payment was sought.<sup>8</sup> Subsequent legislation, which remains in effect today, provided for the establishment of state-controlled Medicaid Fraud Control

recognized poverty level).

5. See Comment, *White Collar Crime: A Survey of Law*, 18 AM. CRIM. L. REV. 169, 287 (1980). See also Cohen, *supra* note 4, at 44. See generally Pontell, Jesilow & Geis, *Policing Physicians: Practitioner Fraud and Abuse in a Government Medicaid Program*, 30 SOC. PROB. 117 (1982); Lee, *Fraud and Abuse in Medicare and Medicaid*, 30 AD. L. REV. 1 (1978); Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 245 n.6 (1978).

6. See Cohen, *supra* note 4, at 44. It is difficult to determine exactly how much of the over \$22 billion spent annually by the federal and state governments for Medicaid is spent improperly. Estimates suggest that up to 20% of money expended has been misapplied for unnecessary services or fraudulent billing. NATIONAL ASS'N. OF ATTORNEYS GENERAL, CONTROLLING MEDICAID FRAUD 5 (1977).

In 1983 hearings by the Senate Special Committee on Aging, Chairman John Heinz stated:

Over the past 15 years, this committee has uncovered extensive and dramatic examples of the problems inherent in our present cost-based retrospective payment system of health insurance. We have documented shocking examples of fraud, waste, and abuse, which I estimated last fall to amount to the stunning total of \$10 billion annually in both Medicare and Medicaid. . . . It is a measure of the failure of our present reimbursement system that these fraud, waste and quality of care problems have proved resistant to all of our determined efforts to eliminate them.

*Quality Assurance Under Prospective Reimbursement Programs: Hearing Before the Select Committee on Aging*, 98th Cong., 1st Sess. 2-3 (1983). See generally *Medicaid Payments for Ineligible Persons: Hearing before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives*, 95th Cong., 1st Sess. 1-3 (1977) (statement of Joseph Califano on improper and wasteful payments in the Medicaid program); *Fraud and Racketeering in Medicare and Medicaid: Hearing before the House Select Committee on Aging*, 95th Cong., 2d Sess. 14-15 (1978) (statement of Congressman John Abner estimating that fraud consumes up to 10% of federal expenditures for health and welfare programs).

7. See generally Inglehart, *Health Policy Report Medical Care of the Poor — A Growing Problem*, 313 NEW ENG. J. MED. 59 (1985); Wing, *Recent Amendments to the Medicaid Program: Political Implications*, 74 AM. J. PUB. HEALTH 83 (1984).

8. Social Security Amendments of 1967, Pub. L. No. 90-248, § 234(a), 81 Stat. 821, 906 (1968) (current version at 42 U.S.C. § 1396a(a)(27) (1982)).

Units for the investigation and prosecution of criminal violations.<sup>9</sup>

In 1977, Congress responded to widespread fraud within the program by enacting the Medicare-Medicaid Anti-Fraud and Abuse Amendments.<sup>10</sup> These statutes augmented existing statutory provisions by reclassifying as felonies most fraudulent billing practices of health care providers and expanding penalties for their violation.<sup>11</sup> The amendments further empowered the Secretary of the Department of Health and Human Services to suspend convicted providers from further participation in the program,<sup>12</sup> and required public disclosure of the names of providers who had been convicted of Medicaid offenses.<sup>13</sup>

### B. *The Issue*

Among physicians who have been sanctioned for abuse of government medical benefit programs, psychiatrists comprise a disproportionately large share of the total.<sup>14</sup> Eight percent of the approximately 380,000 physicians currently practicing in the United States are psychiatrists.<sup>15</sup> From the advent of the Medi-

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9. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, § 17(c), 91 Stat. 1175, 1201-02 (1977) (current version at 42 U.S.C. § 1396b(q) (1982)).

10. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, 91 Stat. 1175 (1977) (codified as amended in scattered sections of 5, 26 and 42 U.S.C.). Prior to 1977, prosecution of Medicaid fraud generally occurred through the combined application of 18 U.S.C. §§ 287, 1001 (1982) (federal false claims provisions); 31 U.S.C. §§ 231-35 (1982) (federal false claims provisions); 42 U.S.C. § 1395nn (1982); and 42 U.S.C. § 1396h (1982).

11. Maximum penalties were increased to fines of up to \$25,000 or up to five years imprisonment, or both. 42 U.S.C.A. § 1395nn(a), 42 U.S.C.A. § 1396h(a) (1982 & West Supp. 1985).

12. 42 U.S.C.A. § 1395y(e) (1982 & West Supp. 1985).

13. 42 U.S.C.A. § 1320a-5(a)(2) (1982 & West Supp. 1985). For a detailed analysis of the Medicare-Medicaid Anti-Fraud and Abuse Amendments see Comment, *supra* note 5, at 286-87. See also Laudicina & Schneider, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977: Implications for the Poor*, 11 CLEARINGHOUSE REV. 843 (1978).

14. Geis, Jesilow, Pontell & O'Brien, *Fraud and Abuse of Government Medical Benefit Programs by Psychiatrists*, 142 AM. J. PSYCHIATRY 231, 233 (1985) [hereinafter cited as Geis]. The largest proportion of suspensions involved general practitioners (27%). This figure, however, is approximately equal to their proportion in the medical community. *Id.* See generally Towery & Sharfstein, *Fraud and Abuse in Psychiatric Practice*, 135 AM. J. PSYCHIATRY 92 (1978) (discussing fraudulent and abusive practices in psychiatry).

15. Geis, *supra* note 14, at 231. Approximately 10% of all Medicaid expenditures

caid program in 1967 through 1982, psychiatrists have represented 18.4% of the total number of physicians suspended for Medicaid fraud or abuse.<sup>16</sup>

As part of an investigation of suspected Medicaid billing fraud, the medical records of provider physicians are frequently subpoenaed. In many cases, psychiatrists have refused to produce patient records claiming that these files are protected from disclosure by way of a psychotherapist-patient or physician-patient evidentiary privilege.<sup>17</sup> Psychiatrists have also claimed that such files are protected by the constitutional right of privacy.<sup>18</sup>

In the context of Medicaid fraud investigations, courts have generally focused on an analysis of the psychotherapist-patient privilege when dealing with challenges to subpoenas for psychiatric records.<sup>19</sup> In these decisions, courts have compelled the production of the entire or limited portions of the psychiatric record, regardless of whether or not the privilege had been recognized.<sup>20</sup> Although the constitutional privacy issue has often

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are for psychiatric services. Two-thirds of the financing for psychiatric care comes from the government. *Id.*; Sharfstein, *Fraud Committed by Psychiatrists*, 142 AM. J. PSYCHIATRY 219 (1985).

16. Geis, *supra* note 14, at 231 (suggesting that since psychiatrists charge patients for time rather than for services, they are more readily apprehended than other physicians who also may be guilty of fraudulent billing practices). See also Mitchell & Cromwell, *Medicaid Participation by Psychiatrists in Private Practice*, 139 AM. J. PSYCHIATRY 810 (1982) (Psychiatrists who participated in the Medicaid program were more likely to be foreign medical graduates. Psychiatrists with large Medicaid practices saw significantly more patients each week but spent less time with each patient.).

17. See, e.g., *In re Zuniga*, 714 F.2d 632 (6th Cir. 1983). See also *infra* notes 24-146 and accompanying text.

18. See, e.g., *Hawaii Psychiatric Soc'y, Dist. Branch of the Am. Psychiatric Ass'n v. Ariyoshi*, 481 F. Supp. 1028 (D. Hawaii 1979). See also *infra* notes 147-293 and accompanying text.

Some psychiatrists have also claimed protection under the fifth amendment right against self-incrimination. These claims have been uniformly dismissed. See, e.g., *Grand Jury Subpoena Duces Tecum v. Kuriansky*, 113 A.D.2d 49, 50, 495 N.Y.S.2d 365, 366 (1st Dep't 1985); *Zuniga*, 714 F.2d 632, 642 (6th Cir. 1983); *People v. Doe*, 59 N.Y.2d 655, 656, 450 N.E.2d 211, 212 (1983); *United States v. Witt*, 542 F. Supp. 696, 698 (S.D.N.Y. 1982).

19. Some courts do not recognize a psychotherapist-patient privilege and have based their decision on the physician-patient privilege instead. See cases cited *infra* notes 37-49 and accompanying text.

20. *Zuniga*, 714 F.2d at 642. (While acknowledging the "compelling necessity" for recognition of the psychotherapist-patient privilege, the court nonetheless ordered the production of records containing the names of patients, the dates of treatment and the length of treatment on each date.); *In re Grand Jury Investigation*, 441 A.2d 525, 531

been raised in lower courts and on appeal, no court has yet to fully analyze and resolve the issue of whether such a right protects against disclosure of patient files.<sup>21</sup>

Attorneys for psychotherapists have urged that, in the context of Medicaid fraud investigations, the constitutional right of privacy affords greater protection for psychotherapeutic records than does the physician-patient or psychotherapist-patient privilege.<sup>22</sup> Testing this hypothesis, this Comment will analyze and compare those protections afforded by the evidentiary privileges and the constitutional right of privacy as they apply to psychotherapeutic records.

Part II of this Comment begins with a discussion of the psychotherapist-patient evidentiary privilege: its common law and statutory origins, and its application by the courts in cases involving the compelled disclosure of psychiatric records in Medicaid fraud investigations. The constitutional right of privacy will be discussed in Part III with a comparative eye toward the psy-

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(R.I. 1982) (noting statutorily created patient-physician privileges stand as an obstacle to the accomplishment and execution of federal medicaid laws, which require disclosure of patient records for fraud investigations and, as such, must yield to federal law); *Camperlengo v. Blum*, 56 N.Y.2d 251, 252, 436 N.E.2d 1299, 1300, 451 N.Y.S.2d 593, 594 (1982) ("The physician-patient privilege does not absolutely protect a doctor's records of treatment of Medicaid patients from a subpoena of the State Department of Social Services issued in an investigation of billing practices.").

21. In *Zuniga*, the Sixth Circuit assumed arguendo that the constitutional right of privacy encompassed patients' interests in preventing disclosure of personal information sought by a grand jury. Due to the extremely limited nature of the information sought in the grand jury investigation, a detailed analysis of the constitutional issue was not carried out. In *Ariyoshi*, although the District Court of Hawaii did provide guidelines for the analysis of constitutional privacy rights as they apply to psychiatric records, the court did not complete its constitutional analysis. The plaintiff's objective in *Ariyoshi* was to obtain an injunction to forestall enforcement of a Hawaii statute authorizing the issuance of administrative inspection warrants to search the records and offices of Medicaid providers. Since the court was considering preliminary injunctive relief, it assessed only the probability of success on the merits and did not decide the constitutionality of the Hawaii statute. *Ariyoshi*, 481 F. Supp. at 1036.

The Supreme Judicial Court of Massachusetts in *Commonwealth v. Kobrin*, 395 Mass. 284, 479 N.E.2d 674 (1985) also failed to consider the constitutional privacy claims of a psychiatrist challenging subpoenas for his records pursuant to a Medicaid fraud investigation. The court noted that since communications between a patient and psychotherapist were already protected by state privilege law, the federal constitutional issue need not be reached. 395 Mass. at 288 n.9, 479 N.E.2d at 678 n.9. See also *Camperlengo*, 56 N.Y.2d at 253, 436 N.E.2d at 1301, 451 N.Y.S.2d at 595 (1982) (constitutional issue not raised in lower court; therefore, not considered on appeal).

22. See *Blodgett, Private Therapy*, A.B.A. J., July 1985, at 27, 27-28.

chotherapist-patient privilege. In the context of Medicaid fraud investigations and subpoenaed psychotherapeutic records, courts hearing both the evidentiary privilege and constitutional right arguments have identified several factors as determinative of the scope of protection to be afforded such records. These factors include the magnitude of the state interest in the production of confidential psychiatric records and the degree of intrusion into privacy occasioned by such disclosures. The existence of safeguards designed to prevent unnecessary disclosures of private information is a prime element in an evaluation of the intrusiveness of disclosure of confidential information. The existence and scope of such safeguards will be addressed in Part IV.

This Comment concludes that, in the context of Medicaid fraud investigations, the protections afforded psychotherapeutic records through the constitutional right of privacy are no greater nor broader in scope than those generally provided through a psychotherapist-patient privilege. Courts faced with claims of protection under the constitutional right of privacy or the evidentiary privilege must utilize a balancing analysis, weighing the societal and governmental interests in favor of disclosure against the societal and individual interests in maintaining the confidentiality of the records.

Thus, records which do not contain confidential psychotherapeutic communications or which are redacted so as to mask the identities of patients are unlikely to be protected against compelled disclosure due to the limited intrusion into privacy interests occasioned by such disclosure. This is particularly true in light of the existence of various safeguards designed to protect records, once produced by therapists, against additional unnecessary disclosure. Unredacted records which contain confidential patient disclosures and other intimate data are likely to be protected against compelled disclosure under both the constitutional right and the psychotherapist-patient privilege. This is because of the substantial insult to individual privacy interests effectuated by such disclosure and the fact that the effectiveness of Medicaid fraud investigations is unlikely to be substantially enhanced by the production of such confidential data. As such, in the context of Medicaid fraud investigations, protections afforded psychotherapeutic records under the constitutional right of privacy are substantially similar to those provided by the psy-

chotherapist-patient privilege.<sup>23</sup>

## II. The Psychotherapist-Patient Privilege

### A. History of the Privilege

For over 300 years, a fundamental legal maxim has existed declaring that "the public has a right to every man's evidence."<sup>24</sup> In contrast to this maxim, the law recognizes certain communications which are protected from disclosure in legal proceedings. Unlike other rules of exclusion which guard against the admission of unreliable or misleading evidence,<sup>25</sup> the laws of privilege are based solely on a societal interest in fostering certain relationships.<sup>26</sup>

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23. See *infra* note 314.

24. See 8 J. WIGMORE, EVIDENCE § 2192, at 71 (McNaughton rev. 1961 and Supp. 1985). In the debate concerning a bill to pardon, in advance, witnesses who might incriminate themselves in the fraud committed by Sir Robert Walpole, Earl of Oxford, Lord Hardwicke, arguing against the bill stated:

It has, my lords, I own, been asserted by the noble duke, that the public has a right to every man's evidence, — a maxim which in its proper sense cannot be denied. For it is undoubtedly true that the public has a right to all the assistance of every individual.

*Id.* (quoting 12 COBBETT'S PARLIAMENTARY HISTORY 675, 693 (n.d.)).

See also *United States v. Bryan*, 339 U.S. 323, 331 (1949); *Branzburg v. Hayes*, 408 U.S. 665, 688 (1972) (describing the duty to give evidence as "particularly applicable to grand jury proceedings").

25. Among the most common exclusionary rules are the hearsay rule (FED. R. EVID. 802), the rules barring most opinion evidence (FED. R. EVID. 602, 701), the rule against character evidence admitted to show propensity toward criminal behavior (FED. R. EVID. 404), and the rule favoring admission of an original document over secondary evidence (FED. R. EVID. 1002). See generally C. McCORMICK, EVIDENCE § 72, at 170-71 (3d ed. 1984).

26. See C. McCORMICK *supra* note 25, § 72, at 171. See also *State v. 62.96247 Acres of Land in New Castle County*, 57 Del. 40, 193 A.2d 799 (1963). Commenting on the rules governing privileged communications, the court held that:

the duty of the confidant of nondisclosure of confidential communications is imposed to protect the reliance interest of the communicant, with an assent of the community. This reliance interest is protected because such protection will encourage certain communications. Encouraging these communications is desirable because the communications are necessary for the maintenance of certain relationships. It is socially desirable to foster the protected relationships because other results are achieved, such as the promotion of justice, public health and social stability. These goals are promoted in furtherance of a well-organized, peaceful society, which in turn is considered necessary for human survival.

*Id.* at 50, 193 A.2d at 807.

See also Austin, *The Use of Privileged Communications for Impeachment Pur-*



Such privileged relationships most commonly include husband-wife,<sup>27</sup> attorney-client,<sup>28</sup> and priest-penitent.<sup>29</sup> These relationships have been deemed by society to be of sufficient import to justify protection through evidentiary privileges despite the possible sacrifice of otherwise admissible and probative evidence.<sup>30</sup> Because such evidentiary privileges result in the withholding of information from the triers of fact, however, they "are not lightly created nor expansively construed, for they are in derogation of the search for truth."<sup>31</sup>

The roots of the modern psychotherapist-patient privilege can be found in the long tradition of recognizing as confidential communications between physicians and their patients.<sup>32</sup> At

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poses, 49 N.Y. St. B.J. 564 (1977) (suggesting a second rationale for recognition of certain privileges in that they protect the essential privacy inherent in certain significant human relationships).

27. See, e.g., *Hawkins v. United States*, 358 U.S. 74 (1958) (recognizing the privilege of an accused in a criminal case to prevent his or her spouse from testifying).

28. See generally C. McCORMICK, *supra* note 25, §§ 87-97 (3d ed. 1984). The roots of the attorney-client privilege may extend as far back as Roman law. See Comment, *The Privilege of Confidential Communication Between Lawyer and Client*, 16 CALIF. L. REV. 487, 488 (1928).

29. See generally C. McCORMICK, *supra* note 25, § 77, at 186.

30. C. McCORMICK, *supra* note 25, § 72, at 171. Various other privileges have been asserted. See *Branzburg v. Hayes*, 408 U.S. 665 (1972) (reporters and their sources); *United States v. Doe*, 460 F.2d 328 (1st Cir. 1972) (researchers and their sources); *United States v. Wainwright*, 413 F.2d 796 (10th Cir. 1969) (accountants and their clients); *In re Verplank*, 329 F. Supp. 433 (C.D. Cal. 1971) (draft counselors and their clients); *Gottlieb v. Bresler*, 24 F.R.D. 371 (D.D.C. 1959) (insurance companies and their insureds).

31. *United States v. Nixon*, 418 U.S. 683, 710 (1974). See also *McMann v. SEC*, 87 F.2d 377, 378 (2d Cir. 1937) (In denying a claim of privilege by a customer against disclosure of his investment broker's records, Judge Learned Hand indicated that, "The suppression of truth is a grievous necessity at best, more especially when as here the inquiry concerns the public interest; it can be justified at all only when the opposed private interest is supreme.").

32. The Hippocratic Oath states in part: "Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not be spoken of abroad, I will not divulge as reckoning that all such be kept secret."

It is significant to note that neither the Hippocratic Oath nor the modern ethical standards promulgated by the American Medical Association require absolute confidentiality. The modern restatement of the Hippocratic Oath adopted in the American Medical Association's Principles of Medical Ethics permits physicians to divulge confidential information when required by law. "The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest degree possible. . . . The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law." AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE JUDICIAL COUNCIL 19 (1984).

common law, however, no physician-patient evidentiary privilege was recognized.<sup>33</sup> In 1829, New York became the first state to enact a specific statutory physician-patient privilege.<sup>34</sup> Today, most states have adopted some form of physician-patient or psychotherapist-patient privilege.<sup>35</sup> The psychotherapist-patient privilege has also been recognized in the federal system through judicial interpretation of the Federal Rules of Evidence.<sup>36</sup>

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See also Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 176 n.6 (1960) (discussing the prior restatement of the Hippocratic Oath).

33. Denouncements of the physician-patient privilege can be found as early as 1776. In the bigamy trial of the Dutchess of Kingston, the court, in compelling the noblewoman's physician to testify stated:

If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but, to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever.

The Trial of the Dutchess of Kingston, 20 How. St. Tr. 355, (Parl. Cas. 1776). See Slovenko, *supra* note 32, at 177.

Contemporary courts have echoed these sentiments. "The considerations which relate to physicians and their patients do not require that an exception should be made to the general liability of all persons to give testimony upon all facts that are the subject of legitimate inquiry in the administration of justice." *United States v. Kansas City Lutheran Home and Hosp. Ass'n*, 297 F. Supp. 239, 244 (W.D. Mo. 1969); see *Barnes v. United States*, 374 F.2d 126 (5th Cir. 1967).

34. The 1829 statute reads as follows:

No person duly authorized to practice physic or surgery, shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him, as a surgeon.

2 N.Y. REV. STAT., pt. 3, ch. VII, § 73 (1st ed. 1829), (codified as amended at N.Y. CIV. PRAC. LAW § 4504 (McKinney 1986)). See generally Note, *Patient Testimonial Privileges Under the Proposed Code of Evidence for New York*, 45 ALB. L. REV. 773 (1981) (discussing the history of the physician-patient privilege in New York).

Interestingly, soon after enactment, this physician-patient privilege was denounced by Dean John Wigmore. Dean Wigmore set forth four conditions necessary to establish a privilege against the disclosure of communications. They are: (1) the communication must be made in the belief that it will not be disclosed; (2) confidentiality must be essential to the maintenance of the relationship between the parties; (3) the relationship should be one that society considers worthy of being fostered; and (4) the injury to the relationship caused by disclosure must be greater than the benefit gained in obtaining the testimony. 8 J. WIGMORE, *supra* note 24, § 2285, at 527 (3d ed. 1940 and Supp. 1985).

Dean Wigmore maintained that the physician-patient relationship met only the third condition and, therefore, should not be privileged. *Id.* §§ 2380-91.

35. See Comment, *Evidence Law — The Psychotherapist-Patient Privilege in Federal Courts*, 59 NOTRE DAME L. REV. 791, 791-92 (1984).

36. Federal Rule of Evidence 501 provides for all testimonial privileges to be "governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience." FED. R. EVID. 501.

## B. Differentiating the Privileges

Fundamental differences between the psychotherapist-patient and physician-patient relationships dictate that they be afforded separate and distinct recognition and treatment. The most significant distinction between the two is the nature of the information exchanged in each relationship.<sup>37</sup>

Many physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a psychiatrist must have his patient's confidence or he cannot help him. "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. . . . 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."<sup>38</sup>

Psychiatric literature is replete with assertions that confidentiality is crucial to effective psychotherapy.<sup>39</sup> Studies have demonstrated that potential breaches in the confidential relationship between patient and therapist have resulted in disinclinations to enter therapy<sup>40</sup> and reluctance to convey to the therapist information vital to successful treatment.<sup>41</sup> Thus, com-

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Analyzing this rule, the U.S. Court of Appeals for the Sixth Circuit, in *In re Zuniga*, determined that federal law did indeed recognize a psychotherapist-patient privilege. 714 F.2d 632, 638-40. See discussion *infra* notes 48, 50, 60-90 and accompanying text.

37. A second distinction lies in the context in which the information becomes the subject of judicial inquiry. It is rare that the records of a psychotherapist receive judicial attention at the request of the patient himself, while non-psychiatric testimony is often admitted into evidence because the patient himself made it the subject of litigation. When a third party and not the patient himself seeks access and use of such information, the potential for abuse and prejudice is certainly intensified.

38. *Taylor v. United States*, 222 F.2d 398, 401 (2d Cir. 1955) (quoting Overholser, *Some Problems of the 'Criminal Insane' at Saint Elizabeths Hospital*, 22 MED. ANNALS OF D.C. 349 (1953)).

39. See, e.g., Dubey, *Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*, 131 AM. J. PSYCHIATRY 1093 (1974); Schwed, Kuvin & Baliga, *Medicaid Audit: Crisis in Confidentiality and the Patient-Psychiatrist Relationship*, 136 AM. J. PSYCHIATRY 447 (1979); Grossman, *Insurance Reports as a Threat to Confidentiality*, 128 AM. J. PSYCHIATRY 64, 67 (1971). See also *infra* notes 40-43 and accompanying text.

40. See Meyer & Smith, *A Crisis in Group Therapy*, 38 AM. PSYCHOLOGIST 638 (1977).

41. See Comment, *Where the Public Peril Begins: A Survey of Psychotherapists to*

elling a breach in the confidentiality of the psychotherapeutic relationship may be counterproductive to important societal interests in fostering treatment for the emotionally disturbed,<sup>42</sup> and may additionally place therapists in a professionally and morally intolerable position.<sup>43</sup>

The threat of compelled disclosure of psychiatric records not only has a direct deleterious effect on the patient and the psychotherapeutic relationship, it also threatens the effectiveness of future therapy. Fearing possible disclosure, therapists treating Medicaid patients may alter their recordkeeping routines, omitting certain patient communications or other significant revelations.<sup>44</sup> Such omissions may retard the therapeutic

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*Determine the Effect of Tarasoff*, 31 STAN. L. REV. 165, 182-84 (1978) (study revealed approximately one fourth of surveyed therapists had observed a reluctance to discuss violent tendencies when patients were informed of a possible breach of confidentiality). See generally, *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (holding that psychotherapists owe an affirmative duty to third parties threatened by patients under the psychotherapists' care).

42. One commentator has suggested:

It seems to this writer that any values to judicial administration inherent in attempts to force the psychotherapist to disgorge the secrets of his patients are overbalanced by: (1) the inducement to perjury implicit in such attempts and (2) the harm to the human personality, and hence to freedom, in governmental forcing of a serious conflict of conscience.

Louisell, *The Psychologist in Today's Legal World: Part II* 41 MINN. L. REV. 731, 750 (1957).

43. The maintenance of confidentiality is required by the codes of ethics of most major psychiatric and psychological organizations. See American Psychiatric Association, *Position Statement on Confidentiality and Privilege with Special Reference to Psychiatric Patients*, 124 AM. J. PSYCHIATRY 175, 175-76 (1968); American Psychological Association, *Standards for Providers of Psychological Services*, APA MONITOR, March 1975 at 19.

44. In *Hawaii Psychiatric Soc'y, Dist. Branch of the Am. Psychiatric Ass'n v. Ariyoshi*, 481 F. Supp. 1028, 1042 (D. Hawaii 1979) the court noted that:

Psychiatrists may be disinclined to record in their files extremely personal, sensitive confidences of a patient if they know those files may be reviewed and copied by state officials at any time. The threat of searches may therefore decrease the likelihood that the very information most valuable to another treating psychiatrist, a history of the patient's emotional and mental problems, will be available.

*Id.*

See also Sharfstein, Towery & Milowe, *Accuracy of Diagnostic Information Submitted to an Insurance Company*, 137 AM. J. PSYCHIATRY 70 (1980) (study demonstrated that diagnostic information submitted to insurance companies by psychiatrists is often inaccurate because of concerns about patient confidentiality).

Some authorities have suggested that psychotherapists keep billing records separate from those containing confidential communications. Others have suggested that psycho-

capacity of subsequent treating psychotherapists who, in necessary reliance on these records, will consequently lack a complete and accurate history of the patient's illness.<sup>45</sup>

There is "a growing consensus throughout the country, reflected in a trend of legislative enactments, acknowledg[ing] that an environment of confidentiality of treatment is vitally important to the successful operation of psychotherapy."<sup>46</sup> Indeed, the trend in both state and federal courts is toward acknowledgment of the unique nature of the psychotherapist-patient relationship<sup>47</sup> and toward granting the psychotherapist-patient privilege recognition independent of the physician-patient privilege.<sup>48</sup> The

therapists keep no records whatsoever regarding patient communications. See generally Slovenko, *On the Need for Record Keeping in the Practice of Psychiatry*, 7 J. PSYCHIATRY & L. 399, 400-01 (1979); HOFLING, *LAW AND ETHICS IN THE PRACTICE OF PSYCHIATRY*, 77-81 (1981).

45. See Mitchell, Pyle & Hatsukami, *Requesting Previous Psychiatric Records Do They Come and are They Worth Obtaining?*, 169 J. NERVOUS & MENTAL DISEASES 364, 366 (1981) ("Significant problems which may prove important to diagnosis and treatment may be uncovered through obtaining previous medical records.").

46. *In re Lifschutz*, 2 Cal. 3d 415, 422, 467 P.2d 557, 560-61, 85 Cal. Rptr. 829, 837 (1970). Support for this trend was stated most convincingly in the Advisory Committee's note to Proposed Federal Rule of Evidence 504:

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.

FED. R. EVID. 504 advisory committee note (proposed 1972), (quoting GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 45, 92 (1960)).

47. Commentators in favor of a psychotherapist-patient privilege argue that this privilege satisfies Dean Wigmore's standards for legitimacy, being more analogous to the priest-penitent relationship recognized by him than to the physician-patient relationship which he rejected. See *supra* note 34.

"[T]he psychotherapeutic relationship not only satisfies [Dean Wigmore's four criteria] but satisfies them better than any existing privileged relationship." Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 611 (1974).

48. See *In re Zuniga*, 714 F.2d 632, 639 (6th Cir. 1983); *Caesar v. Mountanos*, 542 F.2d 1064, 1067 (9th Cir. 1976), *Lora v. Board of Educ.*, 74 F.R.D. 565, 575 (E.D.N.Y. 1977); See also FED. R. EVID. 504 advisory committee note (proposed 1972). But see

federal courts, however, have not been uniform in their recognition of the privilege. Acting in accordance with their own interpretation of the standards (or lack thereof) provided in Federal Rule of Evidence 501, individual federal courts have reached inconsistent and often conflicting results.<sup>49</sup>

### C. Federal Rule of Evidence 501

Federal Rule of Evidence 501 establishes a single, general privilege governing the admissibility of confidential communications in the federal courts.<sup>50</sup> This single, general rule was adopted by Congress in 1972 in preference to nine individual and specific rules which were originally proposed by the Advisory Committee on the Federal Rules of Evidence.<sup>51</sup> Among the

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United States v. Witt, 542 F. Supp. 696, 698 (S.D.N.Y.), *aff'd*, 697 F.2d 301 (2d Cir. 1982) (declining to recognize a federal psychotherapist-patient privilege in case involving prosecution for illegal distribution of controlled substances).

Once one accepts the psychotherapist-patient privilege, numerous unanswered questions arise. Who may claim the privilege? What type of therapist qualifies for the privilege? What type of communications should be granted privileged status? What limits must be placed on the general privilege rule? For a discussion of these issues see Note, *The Psychotherapist-Patient Privilege — The Sixth Circuit Does the Decent Thing*: In re Zuniga, 33 KAN. L. REV. 385, 399 (1985).

49. FEDERAL RULE OF EVIDENCE 501 provides:

Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

*Id.*

See, e.g., United States v. Williams, 337 F. Supp. 1114, 1115 (S.D.N.Y. 1971) (holding that a psychotherapist-patient privilege, if one exists, is merely a form of doctor-patient privilege and, therefore, does not apply in federal court absent a specific statute); United States v. Lindstrom, 698 F.2d 1154, 1167-68 (11th Cir. 1983) (holding that a psychotherapist-patient privilege does not exist using reasoning identical to that in *Williams*); *Zuniga*, 714 F.2d 632 (6th Cir. 1983) (recognizing federal psychotherapist-patient privilege in application of Federal Rule of Evidence 501). See also *infra* notes 60-130 and accompanying text.

50. See statute cited *supra* note 49.

51. Rules of Evidence for Federal Courts and Magistrates, 56 F.R.D. 183 (1972). The Advisory Committee on the Rules of Evidence was appointed by Chief Justice Earl Warren on March 8, 1965, and assigned the task of developing uniform rules of evidence for use in the federal courts. The committee, made up of judges, attorneys and educators,

nine rules was a specific privilege protecting communications between patients and psychotherapists.<sup>52</sup>

Legislative history reveals two distinct motivations for the enactment of a single, general provision instead of the originally proposed, more specific rules. First, the enactment of the general rule permitted greater interpretive flexibility in the courts for examining what may be outmoded social policy.<sup>53</sup> This view, echoed by the Sixth Circuit in *In re Zuniga*,<sup>54</sup> draws support from language contained in the Senate Judiciary Committee Report to Rule 501, which disclaims any intention of foreclosing recognition of the nine privileges enumerated in the originally

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completed a preliminary draft of proposed rules in March, 1969. The draft was accompanied by detailed Advisory Committee notes. S. REP. NO. 1277, 93d Cong., 2d Sess. 8, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7051, 7052.

The originally proposed rules included privileges for required reports privileged by statute (FED. R. EVID. 502 (proposed 1972)); lawyer-client privilege (FED. R. EVID. 503 (proposed 1972)); psychotherapist-patient privilege (FED. R. EVID. 504 (proposed 1972)); husband-wife privilege (FED. R. EVID. 505 (proposed 1972)); communications to clergymen (FED. R. EVID. 506 (proposed 1972)); political vote privileges (FED. R. EVID. 507 (proposed 1972)); trade secret privileges (FED. R. EVID. 508 (proposed 1972)); secrets of state and other official information privileges (FED. R. EVID. 509 (proposed 1972)); and privileges regarding the identity of informers (FED. R. EVID. 510 (proposed 1972)).

Although these rules are commonly attributed to the Supreme Court, Justice Douglas pointed out in his dissent to the order prescribing the proposed rules that the Court did not write, supervise the writing of, or rule on the merits of the rules. The rules were the culmination of seven years work by an advisory committee, appointed by Chief Justice Earl Warren. The Court was merely a conduit for transmission of the proposed rules to Congress. Justice Douglas did not, however, deny the Court's approval of the Rules. "[T]he public assumes that our imprimatur is on the Rules, as of course it is." Rules of Evidence for Federal Courts and Magistrates, 56 F.R.D. 183, 185 (1972) (Douglas, J., dissenting).

52. Proposed Federal Rule of Evidence 504 provides in part:

(b) General rule of privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition, including drug addiction, among himself, his psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.

(c) Who may claim the privilege. The privilege may be claimed by the patient, by his guardian or conservator, or by the personal representative of a deceased patient. The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority to do so is presumed in the absence of evidence to the contrary.

FED. R. EVID. 504 (proposed 1972).

53. See *infra* note 55.

54. *Zuniga*, 714 F.2d at 636.

proposed rules.<sup>55</sup>

A second, more cynical rationale suggests that Congress merely conveyed to the courts the distasteful responsibility for a volatile decision that it was having trouble making.<sup>56</sup> Substantial controversy surrounded congressional consideration of the adoption of the proposed rules on privilege. This controversy threatened the passage of the entire set of federal rules. It has, therefore, been suggested that this threat actually prompted Congress' decision to compromise and adopt the present Rule 501.<sup>57</sup>

Regardless of the reasons, the federal courts have retained dominion over decisions regarding all evidentiary privileges. When faced with a claim of privilege, individual courts are free to recognize and apply the privilege in light of their interpretation of the facts of each case and of "reason and experience."<sup>58</sup> On the question of the psychotherapist-patient privilege, results have been diverse and often inconsistent.<sup>59</sup>

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55. The Senate Report states, in part:

It should be clearly understood that, in approving this general rule as to privileges, the action of Congress should not be understood as disapproving any recognition of a psychiatrist-patient, or husband-wife, or any other enumerated privileges contained in the Supreme Court's rules. Rather, our action should be understood as reflecting the view that a recognition of privilege based on a confidential relationship and other privileges should be determined on a case-by-case basis.

S. REP. NO. 1277, 93d Cong., 2d Sess. 8, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7051, 7059.

56. In a special note on the laws of privilege, the Senate Report stated:

From the outset, it was clear that the context of the proposed privilege provisions was extremely controversial [sic]. Since it was clear that no agreement was likely . . . the determination was made that the specific privilege rules proposed by the Court would be eliminated . . . leaving the law . . . to be developed by the courts of the United States utilizing principles of the common law.

S. REP. NO. 1277, 93d Cong., 2d Sess. 8, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7051, 7053.

57. For a detailed discussion of the controversy surrounding the passage of the privilege section of the Federal Rules of Evidence, see Comment, *Evidence Law — The Psychotherapist-Patient Privilege in Federal Courts*, 59 NOTRE DAME L. REV. 791, 801-10 (1984).

58. See FED. R. EVID. 501, *supra* note 50.

59. See *infra* notes 63-89 and accompanying text.



## D. Judicial Treatment of the Psychotherapist-Patient Privilege

### 1. Federal Court

Federal Rule of Evidence 501 requires that the law of privilege be governed by the principles of common law as interpreted in the light of "reason and experience." A minority of courts align themselves strictly with the common law, refusing to recognize any psychotherapist-patient privilege whatsoever.<sup>60</sup> These decisions fail to appreciate the inherent differences in the physician-patient and psychotherapist-patient relationships.<sup>61</sup> Furthermore, they fail to recognize that in enacting Federal Rule of Evidence 501, Congress had no intention of ending the evolution of privilege law or of unremittedly returning to the common law.<sup>62</sup>

Deciding whether a psychotherapist-patient privilege indeed exists, the United States District Court for the Eastern District of New York, in *Lora v. Board of Education*, considered factors other than the nonexistence of the privilege at common law.<sup>63</sup>

In *Lora*, plaintiffs were black and Hispanic children assigned to Special Day Schools for Socially Maladjusted and Emotionally Disturbed Children (SMED schools). They maintained that standards for identification, evaluation and placement of students into SMED schools were vague, ambiguous, overbroad and applied in a capricious, arbitrary and racially discriminatory manner.<sup>64</sup> To prove their claims, plaintiffs sought pretrial disclosure of fifty randomly selected and redacted diagnostic and referral files.<sup>65</sup> Defendant sought protection against

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60. See *supra* note 49. See also *United States v. Layton*, 90 F.R.D. 520, 525 (N.D. Cal. 1981) (interpreting Federal Rule 501 as adhering strictly to the common law, and, therefore, holding that a psychologist-patient privilege does not exist in federal courts).

61. See *supra* notes 37-48 and accompanying text.

62. See *supra* note 55 and accompanying text.

63. *Lora*, 74 F.R.D. 565 (E.D.N.Y. 1977).

64. *Id.* at 568.

65. The material contained in the diagnostic and referral files was the product of procedures designed to identify emotionally disabled students who may have qualified for placement into SMED schools. When a teacher or school administrator noted that a pupil manifested maladaptive, disruptive, or aggressive behavior, the child was referred to the school guidance counselor who determined whether a detailed psychological assessment was warranted. If so, the counselor assembled all data pertinent to the case including an educational profile, information regarding the pupil's contacts with courts,

compelled production of the documents asserting, *inter alia*, that the materials were protected by the federal psychotherapist-patient privilege and therefore immune from discovery.<sup>66</sup> Interpreting Federal Rule of Evidence 501 as requiring a balancing of interests for and against application of a specific evidentiary privilege,<sup>67</sup> the *Lora* court acknowledged the inherent differences in the physician-patient and psychotherapist-patient relationships and the substantial societal interest in fostering the latter.<sup>68</sup> This societal interest, coupled with the interests of the individual students in protecting their privacy,<sup>69</sup> was weighed against two factors: the general need for all relevant evidence in litigation and the specific need in this case, in which the quality of remedial education of emotionally disturbed children was at issue.<sup>70</sup>

The *Lora* court concluded that under the facts of this case, the balance tipped on the side of compelled disclosure. The court granted plaintiff's motion for an order compelling production of redacted portions of the fifty student files.<sup>71</sup> Protective

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clinics, hospitals and social agencies. This data was screened by a registered psychologist or registered social worker who determined if placement in a SMED school was indicated. If it was so determined, a three-part evaluative study was conducted including a psychological examination of the pupil, a casework study of the family by a social worker and a psychiatric consultation or examination. All materials collected during evaluation and diagnosis were maintained in the students' files.

In making their pretrial discovery motion, plaintiffs sought to have the randomly selected files examined by experts so as to determine if the referral process was carried out in a racially discriminatory fashion. *Id.* at 568.

66. *Id.* at 569.

67. "The granting or withholding of any privilege requires a balancing of competing policies." *Id.* at 578 (quoting *Carr v. Monroe Mfg. Co.*, 431 F.2d 384, 388 (5th Cir. 1970)).

68. *Lora*, 74 F.R.D. at 574-76.

69. *Id.* at 578. The privacy interests of the individual students were deemed to be substantially reduced since their identities were effectively masked and the records to be released were to be further protected against unnecessary disclosure by protective court order. See *infra* note 72.

70. *Id.* at 579. Four significant factors were identified by the *Lora* court to be used in determining whether disclosure of the records would unreasonably interfere with the privacy expectations of the students and their families:

First, is the identification of the individuals required for effective use of the data? Second, is the invasion of privacy and risk of psychological harm being limited to the narrowest possible extent? Third, will the data have been supplied only to qualified personnel under strict controls over confidentiality? Fourth, is the data necessary or simply desirable?

*Id.*

71. *Id.* at 587.

orders, designed to protect the privacy of the students whose records were produced, were also issued.<sup>72</sup>

In 1983, the Sixth Circuit in *Zuniga*<sup>73</sup> engaged in a similar analysis in adjudicating a refusal on the part of psychiatrists to comply with subpoenas duces tecum issued pursuant to a grand jury investigation of fraudulent billing practices.<sup>74</sup> The psychiatrists argued, inter alia, that the documents sought by the grand jury<sup>75</sup> were protected from disclosure by the psychiatrist-patient privilege.<sup>76</sup> In determining whether federal law recognized a psychiatrist-patient privilege, the court looked to Federal Rule of Evidence 501 and its legislative history, noting that the congressional decision not to enact proposed Federal Rule of Evidence 504, a specific psychotherapist-patient privilege,<sup>77</sup> "[did] not preclude recognition of a psychotherapist-patient privilege" in the federal courts.<sup>78</sup>

Indeed, the *Zuniga* court recognized the unique relationship which exists between a psychotherapist and patient and deliberately avoided equating psychotherapists with other physicians.<sup>79</sup> The court then performed a balancing test, weighing the societal interest in the availability of evidence in criminal proceedings

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72. In addition to requiring that all identifying data included in the files be redacted, the court ordered that the information contained in the files be used solely for the purpose of the impending litigation; that the number of copies to be made of the documents be rigidly regulated; that files submitted to the court be sealed; that all material must be returned to the defendants upon conclusion of the suit; and that strict confidentiality be enforced under penalty of contempt of court. *Id.* at 582-83, 587.

73. *Zuniga*, 714 F.2d at 632.

74. *Id.* at 636.

75. The grand jury subpoena ordered production of patient appointment books, sign-in sheets, the doctor's daily log book, redacted copies of patient files (indicating patient name, date of treatment and type of therapy rendered), original patient ledger cards and any other forms, records or memoranda supporting the services rendered. *Id.* at 638.

76. *Id.* at 636.

77. See also *supra* notes 52-57.

78. *Zuniga*, 714 F.2d at 637.

79. *Id.* at 638. The court cited a number of cases in which the psychotherapist-patient privilege was not recognized: *United States v. Lindstrom*, 698 F.2d 1154 (11th Cir. 1982); *United States v. Meagher*, 531 F.2d 752 (5th Cir. 1976); *United States v. Witt*, 542 F. Supp. 696 (S.D.N.Y. 1982). The *Zuniga* court noted that in these cases, the courts simply equated the psychotherapist-patient privilege with the physician-patient privilege, without analyzing the unique aspects of the psychotherapeutic relationship. As such, the *Zuniga* court found these authorities to be unpersuasive. *Zuniga*, 714 F.2d at 638.

against the interests promoted by recognition of the privilege.<sup>80</sup> The court found that the latter interests "in general outweigh the need for evidence in the administration of criminal justice"<sup>81</sup> and that recognition of the psychotherapist-patient privilege, under the facts of the case, was "mandated by reason and experience."<sup>82</sup>

Having acknowledged the "compelling necessity" for the existence of the privilege, the court noted that, "Just as the recognition of privileges must be taken on a case-by-case basis, so too must the scope of the privilege be considered."<sup>83</sup> In determining the scope of the privilege, the court performed a second balancing test, weighing the degree of intrusion into privacy affected by the release of the psychiatrists' files against the need for effective criminal investigation.<sup>84</sup> As the information actually sought by the grand jury in this case was limited,<sup>85</sup> and protected from further unnecessary disclosure by the veil of secrecy attending grand jury proceedings,<sup>86</sup> the court characterized the intrusion into the privacy interests of the psychiatric patients as

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80. Describing the interests promoted by recognition of privilege as "extensive," the court noted:

The inability to obtain effective psychiatric treatment may preclude the enjoyment and exercise of many fundamental freedoms, particularly those protected by the First Amendment. . . . The interest of the patient in exercising his rights is also society's interest, for society benefits from its members active enjoyment of their freedom. Moreover, society has an interest in successful treatment of mental illness because of the possibility that a mentally ill person will pose a danger to the community.

*Zuniga*, 714 F.2d at 639.

81. *Id.*

82. *Id.* In making its determination, the court took into account the demonstrated willingness of individual states to recognize the psychotherapist-patient privilege. See *supra* note 35. The court also considered as determinative the support for such recognition found in the Advisory Committee's Notes to Proposed Federal Rule of Evidence 504 and the support for such recognition provided by various other commentators. *Id.* at 636-39.

83. *Zuniga*, 714 F.2d at 639.

84. *Id.* at 639-41.

85. The subpoenas at issue sought only the names of patients, the dates of treatment and the length of office visits. Documents containing patient's confidential communications or the psychotherapist's confidential notations were not sought by the grand jury subpoena. The identities of patients involved were already known to the grand jury. *Id.* at 642.

86. *Id.* By law, grand jury proceedings are secret and any breach of that secrecy is a criminal offense. See *infra* notes 307-08 and accompanying text.

"minimal."<sup>87</sup> Disclosure was therefore ordered "only to the minimal extent necessary to promote a proper government interest."<sup>88</sup>

The *Zuniga* court provided no specific guidelines as to the proper scope of disclosure which qualifies as the "minimal extent necessary." One factor delineated by the court as prominent in such an analysis was the existence of safeguards designed to prevent unnecessary dissemination of the materials subpoenaed.<sup>89</sup> This factor has been deemed important in a number of federal cases considering compelled disclosure of ostensibly private records.<sup>90</sup>

## 2. State Court

Decisions of state courts considering claims of privilege regarding the disclosure of psychiatric records also have been varied in their approach to the issues and have often yielded inconsistent results.

The Supreme Judicial Court of Rhode Island, in *In re Grand Jury Investigation*,<sup>91</sup> considered two physicians' attempts to quash subpoenas duces tecum issued by a grand jury pursuant to an investigation of suspected Medicaid fraud.<sup>92</sup> The physicians argued that the state's physician-patient privilege<sup>93</sup> protected their medical records against compelled disclosure and

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87. *Zuniga*, 714 F.2d at 642.

88. *Id.*

89. The court did not delineate what safeguards were to be utilized to protect the confidential data from unnecessary disclosure. The court merely ordered that "the information will be disclosed only to the minimal extent necessary to promote a proper governmental interest and will not be subject to widespread dissemination." *Id.*

The *Zuniga* court also did not decide what safeguards would be appropriate should the grand jury investigation lead to a criminal prosecution in which the government would seek to introduce the doctors' records into evidence. *Id.* at 642 n.11.

90. See, e.g., *In re Pebsworth*, 705 F.2d 261, 264 (7th Cir. 1983) (The psychotherapist opposed a grand jury subpoena for patient records pursuant to the investigation of criminal billing fraud upon insurance companies. The court compelled production, emphasizing that access to the patient records would be strictly restricted thereby preserving the confidentiality of the records.). See also *Lora*, 74 F.R.D. at 582; *United States v. Nixon*, 418 U.S. 683, 714 (1973); *Whalen v. Roe*, 429 U.S. 589, 601-02 (1976).

91. *In re Grand Jury Investigation*, 441 A.2d 525 (R.I. 1982).

92. *Id.* at 527.

93. R.I. GEN. LAWS § 5-37.3 (1976) (current version at R.I. GEN. LAWS § 5-37.3 (1986)).

therefore the records were not discoverable by a grand jury.<sup>94</sup>

The Rhode Island court noted that, "A reading of the federal Medicaid laws . . . discloses a clear congressional intention that the patient records kept by health-care providers be subject to disclosure during fraud investigations."<sup>95</sup> As such, the state statutory physician-patient privilege, if given effect, would stand "as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."<sup>96</sup> Thus, the court held that based upon the supremacy clause of the United States Constitution,<sup>97</sup> federal law must prevail and the medical records at issue were obtainable by the grand jury.<sup>98</sup> In a similar case, the New York Court of Appeals, in *Camperlengo v. Blum*,<sup>99</sup> considered a claim that the state statutory physician-patient privilege<sup>100</sup> protected medical records from compelled disclosure in a Medicaid fraud proceeding. In *Camperlengo*, however, the records at issue were psychiatric files which included "all patient records including, but not limited to treatment plans, periodic evaluations and other treatment or diagnostic or prognostic records."<sup>101</sup> The *Camperlengo* court held that the federal and state Medicaid recordkeeping and reporting statutes "evidence a clear intention to abrogate the physician-patient privilege to the extent necessary to satisfy the important public interest in seeing that Medicaid funds are properly applied."<sup>102</sup>

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94. *Grand Jury Investigation*, 441 A.2d at 527.

95. *Id.* at 529.

96. *Id.* at 528 (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 526 (1977)).

97. U.S. CONST. art. VI, cl. 2.

98. *Grand Jury Investigation*, 441 A.2d at 527.

99. 56 N.Y.2d 251, 436 N.E.2d 1299, 451 N.Y.S.2d 697 (1982).

100. N.Y. CIV. PRAC. R. 4504 (McKinney 1981) (current version at N.Y. CIV. PRAC. R. 4504 (McKinney 1986)).

101. *Camperlengo*, 56 N.Y.2d at 254, 436 N.E.2d at 1300, 451 N.Y.S.2d at 698.

102. *Camperlengo*, 56 N.Y.2d at 255-56, 436 N.E.2d at 1301, 451 N.Y.S.2d at 698-99. A similar result was effected in the State of Washington. *State Dep't of Social & Health Servs. v. Latta*, 92 Wash. 2d 812, 601 P.2d 520 (1979). In *Latta*, administrative subpoenas for the full records of Medicaid patients were served on a medical clinic and two pathologists. They asserted the state's statutory physician-patient privilege, arguing that the subpoenaed records were privileged communications. The court ruled the privilege inapplicable to Medicaid investigations but did not do so along strict pre-emption grounds. It was held that "[t]he privilege is a procedural safeguard, not a rule of substantive or constitutional law; therefore, its application turns on the language and interpretation of the statute." *Latta*, 92 Wash. 2d at 812, 601 P.2d at 525. As the purpose of the statute was to prevent public disclosure, this purpose was not violated by releasing the

The petitioner in *Camperlengo* also argued that the information sought by the government was protected by the right of privacy embodied in the Constitution.<sup>103</sup> Because this claim was not raised in the lower courts, however, it was not considered on appeal.<sup>104</sup> In holding that the statutory Medicaid reporting requirements constituted an exception to the state's physician-patient privilege, the court noted that the exception was "to be no broader than necessary for effective oversight of the Medicaid program."<sup>105</sup> The *Camperlengo* court had "no occasion to delineate the precise boundaries of the exception" as the petitioner had abandoned in his appeal any claim that the subpoena was overly broad.<sup>106</sup>

Such an occasion did present itself to the Supreme Judicial Court of Massachusetts in *Commonwealth v. Kobrin*.<sup>107</sup> This case involved a psychiatrist's challenge to a grand jury subpoena for selected Medicaid patient records. The subpoenas, which called for the surrendering of full patient files, were issued pursuant to an investigation of suspected billing fraud.<sup>108</sup> Dr. Kobrin challenged the subpoenas, claiming protection under both the state's statutory psychotherapist-patient privilege<sup>109</sup> and the constitutionally protected right of privacy.<sup>110</sup> Consistent

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ostensibly privileged information to the Department of Health and Social Services which was required under Medicaid to monitor provider services. *Latta*, 92 Wash. 2d at 812, 601 P.2d at 525.

103. *Camperlengo*, 56 N.Y.2d at 256, 436 N.E.2d at 1301, 451 N.Y.S.2d at 595.

104. *Id.*

105. *Id.*

106. *Id.* at 256 n.\*, 436 N.E.2d at 1301 n.\*, 451 N.Y.S.2d at 595 n.\*.

107. 395 Mass. 284, 479 N.E.2d 674 (1985).

108. *Id.* at 285-88, 479 N.E.2d at 676-77.

109. MASS. GEN. LAWS ANN. ch. 233, § 20B (West 1984) (current version at MASS. GEN. LAWS ANN. ch. 233, § 20B (West 1986)).

110. Psychotherapists have generally been granted standing to assert the privacy interests of their patients. See *Hawaii Psychiatric Soc'y, Dist. Branch of the Am. Psychiatric Ass'n v. Ariyoshi*, 481 F. Supp. 1028, 1037 (D. Hawaii 1979); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 682 (1977).

The *Kobrin* court did not reach the constitutional privacy issue. Because the psychotherapeutic communications were already protected against disclosure by state privilege law, the court held that adjudication of the privacy issue was unnecessary. *Kobrin*, 395 Mass. at 288 n.9, 479 N.E.2d at 678 n.9.

See generally *In re B*, 482 Pa. 471, 477, 394 A.2d 419, 421-22 (1978) ("Ordinarily, when faced with an issue raising both constitutional and non-constitutional questions, [courts] will make a determination on non-constitutional grounds and avoid the constitutional issue if possible.").

with the approach taken by federal courts, the *Kobrin* court utilized a balancing approach in evaluating the applicability and scope of the psychotherapist-patient privilege. The federal policy requiring disclosure of records to facilitate the investigation and prosecution of Medicaid fraud,<sup>111</sup> which the court described as "very necessary to the continued viability of the Medicaid program,"<sup>112</sup> was weighed against the "justifiable expectations of confidentiality that most individuals seeking psychotherapeutic treatment harbor."<sup>113</sup> Finding the state interest "compelling,"<sup>114</sup> the court held that the arguments for and against disclosure of the records were not mutually repugnant, but both could be accommodated.<sup>115</sup> The court ordered that those portions of Dr. Kobrin's records which were actually "necessary to fully disclose the extent of the services provided" were to be produced.<sup>116</sup>

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111. This policy is delineated in 42 U.S.C. § 1396a(a)(27) (1982) and 42 C.F.R. § 431.107(b)(1985). The applicable Massachusetts statute requires that all Medicaid providers "maintain proof, subject to audit of the actual deliverance of services and goods to recipients for which bills are submitted." MASS. GEN. LAWS ANN. ch. 118E, § 20 (West 1985).

112. *Kobrin*, 395 Mass. at 290, 479 N.E.2d at 679 (quoting *In re Grand Jury Investigation*, 441 A.2d at 531).

113. *Kobrin*, 395 Mass. at 290, 479 N.E.2d at 679.

114. *Id.* (quoting *Ariyoshi*, 481 F. Supp. at 1041).

115. *Kobrin*, 395 Mass. at 290, 479 N.E.2d at 679.

116. *Id.* at 291, 479 N.E.2d at 679 (emphasis omitted) (citing 42 U.S.C. § 1396a(a)(27)(1982)). Dr. Kobrin was ordered to produce those portions of his records documenting the identity of the patients, the times and length of appointments, fees, diagnoses, treatment plans and somatic therapies. *Kobrin*, 395 Mass. at 284, 479 N.E.2d at 676.

It has been argued that protecting confidential communications alone is insufficient and that the mere identity of psychiatric patients must be privileged so as to maintain an effective psychotherapist-patient relationship. *Zuniga*, 714 F.2d at 640. See also *Lora*, 74 F.R.D. at 580.

Commenting on this, Professor Weinstein has written:

While it can perhaps be said that a client does not ordinarily wish to keep secret the fact that he has consulted a lawyer, the reverse is undoubtedly true in the case of psychotherapy. Some psychiatrists' offices, unlike lawyers, have separate entrances and exits so that a patient can leave without being seen. Non-divulgence of a patient's identity may be essential for maintaining the psychotherapist-patient relationship. . . . Even when suppression of a patient's identity would result in the loss of evidence of criminal conduct, the potential destruction of the therapeutic relationship is of greater concern.

2 J. WEINSTEIN, EVIDENCE § 504, at 504-23 (1985).

The stigma commonly associated with those who receive psychiatric treatment certainly lends support to Weinstein's position. In *Parham v. J.R.*, 442 U.S. 584 (1979), the Supreme Court discussed this social stigma in a case concerning the constitutional re-



Those portions of the records which reflected patients' thoughts, feelings, impressions or which contained the substance of therapeutic dialogue were held to be protected from compelled disclosure.<sup>117</sup> Although the *Kobrin* court did not reach the constitutional privacy issue,<sup>118</sup> the court did consider the privacy concerns underlying the state's psychotherapist-patient privilege.<sup>119</sup>

In 1970, the State of California took this acknowledgement of underlying privacy concerns in privilege statutes one step fur-

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quirements for voluntary admissions of minors to psychiatric hospitals stating: "The pattern of untreated, abnormal behavior — even if nondangerous — arouses at least as much negative reaction as treatment that becomes public knowledge. A person needing, but not receiving, appropriate medical care may well face even greater social ostracism resulting from the observable symptoms of an untreated disorder." *Id.* at 601.

Commenting on this observation by the majority, Justice Stewart wrote: "The fact that such a stigma may be unjustified does not mean it does not exist. . . . The aberrant behavior may disappear while the fact of past institutionalization lasts forever." *Id.* at 622 n.3 (Stewart, J., concurring).

This stigma can affect an individual's employment opportunities. One need only examine the career of Thomas Eagleton who, upon the disclosure of his treatment for depression, was dropped by George McGovern as vice-presidential candidate. See N.Y. Times, Aug. 1, 1972, § 1, at 1, col. 8. See also *Lessard v. Schmidt*, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972) ("Evidence is plentiful that a former mental patient will encounter serious obstacles in attempting to find a job").

The *Zuniga* court acknowledged that "[t]his consideration is not insubstantial." 714 F.2d at 640. However, because "the interest of society in obtaining all evidence relevant to the enforcement of its laws commands a high priority," the balance must tip in favor of disclosure. *Id.*

The essential element of the psychotherapist-patient privilege is its assurance to the patient that his innermost thoughts may be revealed without fear of disclosure. Mere disclosure of the patient's identity does not negate this element. Thus, the Court [sic] concluded that, as a general rule, the identity of a patient or the fact and time of his treatment does not fall within the scope of the psychotherapist-patient privilege.

*Id.*

The *Zuniga* court added that this holding does not mean that a court, at its discretion or compelled by considerations of constitutional privacy, could not protect the identities of patients. 714 F.2d at n.7.

117. *Kobrin*, 395 Mass. 295, 479 N.E.2d at 682. See generally *Pebsworth*, 705 F.2d at 262 ("Fragmentary data" such as names, appointment dates and, in some cases, diagnoses, were distinguished from detailed psychological profiles of patients or substantive accounts of therapy sessions.).

118. See *supra* note 110.

119. The *Kobrin* court noted that in enacting the state's psychotherapist-patient privilege, the Massachusetts legislature acknowledged that most individuals seeking psychotherapy harbor justifiable expectations of confidentiality. 395 Mass. at 290, 479 N.E.2d at 679.

ther and became the first jurisdiction to recognize a constitutionally based psychotherapist-patient privilege.<sup>120</sup> In *In re Lifschutz*,<sup>121</sup> one of Dr. Lifschutz's patients, Joseph Housek, filed a damage suit against the defendant, John Arabian, for assault. Housek's complaint alleged that the assault caused, in addition to physical injuries, "severe mental and emotional distress."<sup>122</sup> Dr. Lifschutz, who had been identified by the plaintiff in a deposition, had treated the plaintiff for a six-month period approximately ten years earlier. The defendant then subpoenaed for deposition Dr. Lifschutz and all of his medical records relating to the treatment of Housek.<sup>123</sup>

Although Dr. Lifschutz appeared for the deposition, he refused to answer questions relating to his treatment of the plaintiff and refused to produce any of his medical records.<sup>124</sup> The psychiatrist was held in contempt of court and ultimately placed in custody for disobeying a court order to divulge the requested information.<sup>125</sup> Arguing against compelled disclosure of his records or testimony, Dr. Lifschutz, inter alia, relied upon the California statutory psychotherapist-patient privilege.<sup>126</sup> The state, however, relying upon the patient-litigant exception to the privilege statute,<sup>127</sup> claimed that since the plaintiff, in instituting

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120. Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1, 1-4 (1980).

121. *In re Lifschutz*, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970).

122. *Id.* at 420, 467 P.2d at 559, 85 Cal. Rptr. at 831.

123. *Id.*

124. Dr. Lifschutz refused even to disclose whether or not Housek had ever consulted him or had been his patient.

125. *Id.*

126. CAL. EVID. CODE § 1014 (West 1969) (current version at CAL. EVID. CODE § 1014 (West 1986)). The code provides, in part:

Except as otherwise provided in this article, the patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:

(a) The holder of the privilege;

(b) A person who is authorized to claim the privilege by the holder of the privilege.

*Id.*

Although notified, neither plaintiff Housek, nor his attorney attended the deposition of Dr. Lifschutz nor did they appear in any of the hearings related to the contempt citation of the psychiatrist. Housek neither claimed a psychotherapist-patient privilege nor expressly waived such a privilege.

127. CAL. EVID. CODE § 1016 (West 1969) (current version at CAL. EVID. CODE § 1016

the litigation, had raised his psychological condition as an issue, the statutory psychotherapist-patient privilege was inapplicable.<sup>128</sup>

The California Supreme Court affirmed the lower court order requiring the production of records and the answering of questions by Dr. Lifschutz. The doctor's contempt citation for intentionally violating the valid court order was affirmed.<sup>129</sup> In so doing, however, the California court recognized a constitutional basis for the psychotherapist-patient privilege.

We believe that a patient's interest in keeping such confidential revelations from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. In *Griswold v. Connecticut*, the United States Supreme Court declared that '[v]arious guarantees [of the Bill of Rights] create zones of privacy,' and we believe that the confidentiality of the psychotherapeutic session falls within one such zone.<sup>130</sup>

While this statement by the California court was dictum, it struck a responsive chord in a number of jurisdictions.<sup>131</sup> Most

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(West 1986)). The code provided:

There is no privilege under this article as to a communication relevant to an issue concerning the mental or emotional condition of the patient if such issue has been tendered by:

- (a) The patient;
- (b) Any party claiming through or under the patient;
- (c) Any party claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or
- (d) The plaintiff in an action brought . . . for damages for the injury or death of the patient.

128. *Lifschutz*, 2 Cal. 3d at 433, 467 P.2d at 569, 85 Cal. Rptr. at 830. Two distinct grounds have been identified by the courts in support of the patient-litigant exception to the physician-patient privilege.

First . . . the patient, in raising the issue of a specific ailment or condition in litigation, in effect dispenses with the confidentiality of that ailment and may no longer justifiably seek protection from the humiliation of its exposure. Second, . . . in all fairness, a patient should not be permitted to establish a claim while simultaneously foreclosing inquiry into relevant matters.

*Id.* See generally 4 J. WIGMORE, EVIDENCE § 2389 at 836-40 (3d ed. 1940 & Supp. 1977).

129. *Lifschutz*, 2 Cal. 3d at 439, 467 P.2d at 573, 85 Cal. Rptr. at 845.

130. *Id.* at 431-32, 467 P.2d at 567, 85 Cal. Rptr. at 839 (quoting *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965)).

131. See, e.g., *Caesar v. Mountanos*, 542 F.2d 1064, 1067-69 (9th Cir. 1976) (discussing at length the privacy-based privilege identified in *Lifschutz*); *Robinson v. Magovern*, 83 F.R.D. 79, 91-92 (W.D. Pa. 1979) (assuming there is "some constitutional right of

of those courts that have examined the constitutional aspects of the psychotherapist-patient privilege have acknowledged that the right of non-disclosure is not absolute. Certain exceptions to the privilege have been deemed acceptable within the constitutional framework.<sup>132</sup> In addition to the patient-litigant exception seen in *Lifschutz*, it has been held that a compelling state interest may also justify interference with the privilege.<sup>133</sup>

Analogous to the patient-litigant exception to the psychotherapist-patient privilege is the exception for communications made by patients expecting disclosure to third parties.<sup>134</sup> In *In re Pebsworth*,<sup>135</sup> the Seventh Circuit addressed whether patients' authorizations for disclosure of their treatment to Blue Cross-Blue Shield constituted a waiver of the state's psychotherapist-patient privilege with regard to information sought by the government pursuant to an investigation of billing fraud.<sup>136</sup> The court ruled that by assenting to publicize their records through the Blue Cross-Blue Shield reimbursement claims procedure, the

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privacy" protecting the doctor-patient relationship); *Miller v. Colonial Refrigerated Transp. Inc.*, 81 F.R.D. 741, 744-46 (M.D. Pa. 1979) (acknowledging existence of constitutional privilege against disclosure of psychotherapeutic communications); *Lora*, 74 F.R.D. at 569-74. *But see* *Felber v. Foote*, 321 F. Supp. 85, 87 (D. Conn. 1970) (holding that there exists no constitutional foundation for the "cloak of confidentiality" which gives a patient the privilege to exclude psychotherapeutic communications from judicial proceedings).

132. *Caesar*, 542 F.2d at 1067. (Psychiatrist contended that the constitutional right of privacy must be construed to provide an absolute privilege for psychotherapeutic communications. The court acknowledged that the right relied upon is substantial. "However, the right is conditional rather than absolute and limited impairment of that right may be allowed if properly justified.") *Id.*

133. *Id.* at 1067-70. *See also* *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (A psychotherapist has a duty to warn potential victims of dangerous patients notwithstanding psychotherapist-patient confidentiality requirements or privileges.).

134. Proposed Federal Rule of Evidence 504(a)(3) stated that "A communication is 'confidential' if not intended to be disclosed to third persons other than those present to further the interest of the patient . . . or those who are participating in the diagnosis and treatment . . ." Rules of Evidence for United States Court and Magistrates, 56 F.R.D. 183, 241 (1972).

135. *Pebsworth*, 705 F.2d at 262.

136. The psychotherapist, Dr. Anita, was accused of fraudulently obtaining reimbursement from medical insurance companies through submission of false psychiatric patient care records. Subpoenas were issued to Mr. Pebsworth, as the authorized representative of Blue Cross-Blue Shield of Illinois, commanding the production of all records concerning Dr. Anita including, inter alia, the names of patients, a listing of their visits, and, in some cases, the patient's diagnosis. *Id.*

patients had knowingly and intentionally relinquished any privilege they may have had.<sup>137</sup>

For such a waiver to be effective, it must be an "intentional relinquishment or abandonment of a known right or privilege."<sup>138</sup> In the Medicaid program, therefore, a waiver of the psychotherapist-patient privilege could only be effective to the extent that the Medicaid patient could be expected to know that particular records were subject to disclosure as a result of the waiver. The State of Hawaii requires that such a waiver be executed by all psychiatric patients enrolled in the state's Medicaid program.<sup>139</sup> This waiver was held to be quite limited in effect.

[I]t would be unreasonable to hold that an indigent patient who signs a form stating that a provider may release certain medical records to the state exercises a knowing waiver of his interest in not having his most personal confidences to the psychiatrist disclosed. It is far more likely that, if he reads the form at all, a patient would assume that the records would include only billing information and similar non-confidential matters.<sup>140</sup>

The determination of the validity of such a waiver would require a case-by-case inquiry into the need for the particular records, as well as the patient's reasonable expectation of the nature of the privilege forfeited.<sup>141</sup> In this regard, it is unlikely that psychiatric patients would, at the commencement of treatment, reasonably believe that they were waiving the confidentiality of their communications by executing an insurance claim form.<sup>142</sup>

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137. *Id.* at 264. The *Pebsworth* court, however, noted:

While we might well have decided differently if the information sought under the subpoena involved detailed psychological profiles of patients or substantive accounts of therapy sessions, it cannot be said that the subsequent disclosure of such fragmentary data as is involved here . . . would be beyond the contemplation of the patients' waiver.

*Id.* at 263.

The Sixth Circuit in *Zuniga* adopted this waiver analysis and ruled that even if the identities and times of treatment were within the scope of the psychotherapist-patient privilege, the patient had waived the privilege to the extent of his disclosure of that information on his insurance form. 714 F.2d at 640-41.

138. *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938). See *Pebsworth*, 705 F.2d at 262.

139. See *Ariyoshi*, 481 F. Supp. at 1045.

140. *Id.*

141. See *Pebsworth*, 714 F.2d at 262-63.

142. Moreover, commentators have noted that, "[o]n the assumption that the privi-

Thus, in the context of Medicaid fraud investigations, the psychotherapist-patient privilege has been found to afford only limited, if any, protection against compelled disclosure of psychiatric records.<sup>143</sup> Although the claims of privilege have occasionally been successful in protecting records containing confidential therapeutic communications, the privilege has not been extended to protect those records, disclosure of which poses a lesser threat to patients' privacy interests.<sup>144</sup> An element often determinative in courts' considerations of privilege claims is the existence of protections against unnecessary disclosure of private information.<sup>145</sup> The presence of such safeguards weighs heavily in favor of disclosure when courts' decisions turn on a balancing of the degree of intrusion into individual privacy interests against the state interest in obtaining evidence in criminal cases.<sup>146</sup>

### III. Constitutional Privacy

#### A. *Historical Origin of The Right*

The concept of a common law right of privacy developed in a large part from two key law review articles. The seminal article, written by Samuel Warren and Louis Brandeis in 1890, attacked the increased intrusion by the press into private lives and urged the preservation of each individual's "inviolable personality."<sup>147</sup> According to Brandeis and Warren, "[t]he common law

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lege is valuable, it is unsound to deny it to a person merely because he is too poor to afford a private physician or private hospital." 5 J. WEINSTEIN, H. KORN & A. MILLER, N.Y. CIV. PRAC., § 4504.12 at 45-217 (1985). In *Pebsworth*, it was argued that the court, by holding that a person's assent to the publicizing aspect of reimbursement and claims procedures, forced patients to make the "unconscionable Hobson's choice of either receiving no treatment or receiving treatment only at the cost of making public their illness." 714 F.2d at 264.

In response to this, the court commented that the grand jury, other official investigative bodies and trial courts "will take scrupulous measures to ensure that there occurs no unnecessary disclosure of patients' names or diagnoses." *Id.*

In this regard, one may also argue that a "Medicaid exception" to the psychotherapist-patient privilege constitutes an impermissible classification based upon wealth and thereby denies Medicaid patients equal protection under the law.

143. See *supra* notes 60-131 and accompanying text.

144. See *supra* notes 116-17 and accompanying text.

145. See *supra* note 90 and accompanying text.

146. See *supra* notes 84-90, 131 and accompanying text.

147. Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

secures to each individual the right of determining, ordinarily, to what extent his thoughts, sentiments and emotions shall be communicated to others."<sup>148</sup>

A second article dealing with the right of privacy was written by Dean William L. Prosser in 1960.<sup>149</sup> Dean Prosser provided a historical review of case law dealing with the right of privacy dating back to the publication of the Warren and Brandeis article in 1890. Focusing on the common law of torts, Dean Prosser indicated that what had emerged from this collection of cases was a complex of four separate torts. He noted that "[t]he law of privacy comprises four distinct kinds of invasion of four different interests of the plaintiff . . . ."<sup>150</sup> They are: an intrusion into a person's private affairs;<sup>151</sup> public disclosure of embarrassing private facts;<sup>152</sup> publicity which creates a false public image;<sup>153</sup> and, appropriation of a person's name or likeness.<sup>154</sup>

It was not until 1965 that the Supreme Court, in *Griswold v. Connecticut*,<sup>155</sup> recognized a specific constitutional right of privacy.<sup>156</sup> In *Griswold*, the Court declared unconstitutional a Connecticut statute which forbade both the use of contraceptives and the aiding or counselling of others in their use.<sup>157</sup> The ma-

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148. *Id.* at 198. As a Justice of the Supreme Court, Brandeis recognized "the right to be let alone — the most comprehensive of rights and the right most valued by civilized men." *Olmstead v. United States*, 277 U.S. 438, 478 (1927) (Brandeis, J., dissenting).

149. Prosser, *Privacy*, 48 CALIF. L. REV. 383 (1960).

150. *Id.* at 389. Prosser indicated that these four torts are tied together by a common name only; otherwise they have "almost nothing in common except that each represents an interference with the right of the plaintiff . . . 'to be let alone.'" *Id.*

151. *Id.*

152. *Id.* Dean Prosser suggested that the leading case in this area is *Melvin v. Reid*, in which the plaintiff was permitted recovery where defendant made a motion picture based on the plaintiff's earlier life as a prostitute. The plaintiff had indeed been a prostitute and the defendant in a sensational murder trial. After her acquittal, she changed her name, abandoned her previous life and began a new life of "rectitude in respectable society" among friends who were unaware of her earlier career. 112 Cal. App. Supp. 285, 297 P. 91 (Dist. Ct. 1931).

153. Prosser, *supra* note 149, at 389.

154. *Id.*

155. 381 U.S. 479 (1965).

156. For a historical overview of the constitutional right of privacy see Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1 (1980).

157. 381 U.S. 484-85. The defendants in *Griswold* were the Executive Director of the Planned Parenthood League of Connecticut and its medical director, a licensed physician. They were convicted of violating a Connecticut statute by providing married persons with information and medical advice on how to prevent conception and, following a

jority opinion, written by Justice Douglas, suggested that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance . . . . Various guarantees create zones of privacy . . . . The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees."<sup>158</sup>

Focusing on the rights of married couples to use contraception, the Court enumerated several reasons which compelled recognition of a constitutional right of privacy. These included: the historical importance of marriage;<sup>159</sup> the private nature of the marital relationship;<sup>160</sup> the private nature of the relationship between the married couple and their physician;<sup>161</sup> and the belief that governmental intrusion into the marital bedroom was improper.<sup>162</sup>

### B. *Constitutional Protection of Medical Records*

Privacy issues in the context of medical records were twice examined by the Supreme Court in the late 1970's. In *Planned Parenthood v. Danforth*,<sup>163</sup> the Court considered, inter alia, the constitutionality of a Missouri statute which imposed certain recordkeeping requirements on physicians and hospitals which performed abortions. Holding that the statute did not violate

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physical examination, prescribing a contraceptive device or material. On appeal, the defendants contended that the statute as applied violated the fourteenth amendment. *Id.* at 480.

158. The amendments named by Justice Douglas as contributing to the right of privacy include the first, third, fourth, fifth and ninth. Concurring opinions by Justices Goldberg, Harlan and White agreed with the majority's conclusion that the Connecticut statute violated the right of privacy but could not agree whether the right emanated from the penumbras of several constitutional guarantees, or from the ninth or fourteenth amendments. *Id.* at 486-507.

159. *Id.* at 486.

160. *Id.* at 482.

161. *Id.*

162. *Id.* In *Eisenstadt v. Baird*, the Court again recognized a constitutional right of privacy, striking down a defendant's conviction for distributing contraceptives to unmarried persons. "If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." 405 U.S. 438, 453 (1972) (emphasis in original).

163. 428 U.S. 52 (1976).



women's constitutional privacy rights,<sup>164</sup> the Court placed great emphasis on the fact that the statute did not actually preclude women from making abortion decisions without governmental interference.<sup>165</sup> The Court also emphasized that the statutory recording requirement did not interfere with the physician-patient relationship; that the records would be useful in maternal-child health issues; and, that the recording requirements offered safeguards to protect the patient's privacy.<sup>166</sup>

In *Whalen v. Roe*,<sup>167</sup> the Supreme Court considered the constitutionality of a New York statute which required the filing of records with the State Health Department of all prescriptions written for certain commonly abused medications.<sup>168</sup> The petitioners in *Whalen* based their objection to the statute on the grounds that the reporting and recording of their use of certain drugs violated their constitutional right of privacy.<sup>169</sup> Reviewing past privacy decisions, the Court determined that there existed at least two specific components of the right of privacy: "the individual interest in avoiding disclosure of personal matters, and . . . the interest in independence in making certain kinds of decisions."<sup>170</sup>

The Court found that the New York statute did not interfere with either interest such as to violate the patients' constitutional rights.<sup>171</sup> The Court based its holding on the fact that the statute itself provided for security against public disclosure of

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164. *Id.* at 81.

165. *Id.* In *Danforth*, the Supreme Court struck down statutory provisions requiring unmarried women under age 18 to obtain consent as a prerequisite to obtaining an abortion. Another provision that was found unconstitutional barred a married woman from obtaining an abortion without her husband's written consent. The Court found that these consent provisions unduly burdened the right to seek abortions by delegating to another the authority to prevent the procedure. *Id.* at 67-75.

166. *Id.* at 80-81.

167. 429 U.S. 589 (1977).

168. N.Y. PUB. HEALTH LAW §§ 3334, 3338 (McKinney 1976) (current version at N.Y. PUB. HEALTH LAW §§ 3334, 3338 (McKinney 1986)).

169. Petitioners, including a group of patients regularly receiving controlled medications and prescribing physicians, claimed that the statute's patient identification provisions invaded the doctor-patient relationship with "a needlessly broad sweep." Claiming that the doctor-patient relationship is one of the zones of privacy accorded constitutional protection, petitioners sought enjoinder of the enforcement of the challenged provisions. *Whalen*, 429 U.S. at 596.

170. *Id.* at 599-600.

171. *Id.* at 603-04.

patient identities;<sup>172</sup> that the disclosures required were not "meaningfully distinguishable" from those often required for public health purposes;<sup>173</sup> that the statute would not deter the legitimate use of the drugs;<sup>174</sup> and, that the statute did not strip patients of their right to decide independently whether or not to use the medications.<sup>175</sup> Therefore, although the Supreme Court acknowledged constitutionally based privacy interests in medical records,<sup>176</sup> the Court held that given sufficient protection against unnecessary public disclosure, individual privacy interests may be sacrificed in favor of compelling societal interests such as deterring drug abuse and protecting maternal health.<sup>177</sup>

### C. Constitutional Analysis

Although the exact boundaries of the "zones of privacy" identified by the Supreme Court in *Griswold* remain largely undefined,<sup>178</sup> the two strands of the right of privacy identified in *Whalen*<sup>179</sup> do provide a foundation from which to initiate a con-

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172. *Id.* at 601.

173. *Id.* at 602. Other examples of statutory reporting requirements relating to public health included those dealing with venereal disease, child abuse, injuries from deadly weapons and fetal death. *Id.* at n.29.

174. *Id.* at 603.

175. *Id.*

176. A perplexing aspect of the *Whalen* decision is the conflicting concurrences by Justices Brennan and Stewart. Justice Brennan maintained that the New York statute did indeed involve constitutionally protected interests in avoiding the disclosure of personal matters and, therefore, was subject to the compelling state interest test. *Id.* at 607 (Brennan, J., concurring).

Justice Stewart, however, made it clear that the Court's earlier decision in *Griswold*, which first recognized a constitutionally based right of privacy, does "not recognize a general interest in freedom from disclosure of private information." *Id.* at 609 (quoting *Katz v. United States*, 389 U.S. 347, 350-51 (1967) (Stewart, J., concurring)). Justice Stewart maintained that there is no general constitutional right of privacy but rather, the protection of a person's general right of privacy is, like the protection of his life and property, left to the law of the individual states. 429 U.S. at 607-09 (Stewart, J., concurring).

177. *Id.* at 607 (Stewart, J., concurring).

178. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684 (1977).

179. See *supra* notes 167-70 and accompanying text. At least one commentator has suggested that there are actually three distinct interests involved in the constitutional right of privacy:

The concept of a constitutional right of privacy still remains largely undefined. There are at least three facets that have been partially revealed, but their form and shape remain to be fully ascertained. The first is the right of the individual to

stitutional analysis. In the context of Medicaid fraud investigations, claims of constitutional privacy must be evaluated in accordance with both the right of independence in decision making and the right of informational privacy.

### 1. *Right of Autonomy In Decision Making*

The element of the right of privacy most clearly recognized by the courts is the right of autonomy,<sup>180</sup> that is, the right to make decisions in areas of fundamental concern, free from unwarranted governmental intrusion.<sup>181</sup> Where fundamental rights are concerned, state action which significantly interferes with these rights may be justified only by a compelling state interest.<sup>182</sup> Such state action must be necessary to advance the compelling state interest and must be narrowly drawn to express only the legitimate governmental interest at stake.<sup>183</sup>

#### a. *Fundamental Interest*

To invoke constitutional protection, the loss of the right of autonomy must involve matters which are "‘fundamental’ or ‘implicit in the concept of ordered liberty.’"<sup>184</sup> The Supreme Court has recognized as fundamental an individual's interest in making decisions free from unjustified governmental intrusion in the areas of marriage,<sup>185</sup> procreation,<sup>186</sup> contraception,<sup>187</sup> family

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be free in his private affairs from governmental surveillance and intrusion. The second is the right of an individual not to have his private affairs made public by the government. The third is the right of an individual to be free in action, thought, experience, and belief from governmental compulsion.

Kurland, *The Private I*, U. OF CHI. MAG., Autumn 1976, 7 at 7-8 (emphasis in original).

180. See generally Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH. L. REV. 1 (1980).

181. Hawaii Psychiatric Soc'y, Dist. Branch of the Am. Psychiatric Ass'n v. Ariyoshi, 481 F. Supp. 1028, 1038 (D. Hawaii 1979).

182. Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

183. Roe v. Wade, 410 U.S. at 155.

184. Roe v. Wade, 410 U.S. at 152 (quoting Palko v. Connecticut, 302 U.S. 319, 325 (1937)).

185. Loving v. Virginia, 388 U.S. 1 (1967).

186. Skinner v. Oklahoma, 316 U.S. 535 (1942).

187. Eisenstadt, 405 U.S. 438; Carey 431 U.S. 678 (1977).

relationships,<sup>188</sup> child rearing and education,<sup>189</sup> and abortion.<sup>190</sup> The Court has further noted that "the outer limits of this aspect of privacy have not been marked by the Court."<sup>191</sup>

In *Whalen*,<sup>192</sup> the Supreme Court implicitly placed decisions regarding medical care within this constitutionally protected zone of the right of autonomy.<sup>193</sup> While decisions regarding medical care and physical health are of paramount personal interest, the concern of an individual for his own mental and emotional health is certainly equal to, if not greater than, his concern for his physical well-being.<sup>194</sup> Indeed, effective psychotherapy may be as important to a person suffering from a mental illness as the opportunity to obtain an abortion is to a woman experiencing an unwanted pregnancy, or as the availability of contraception is to a person desiring to prevent an unwanted pregnancy.<sup>195</sup> Mental illness, left untreated, disrupts thought, decision making and cognition which inevitably results in an interference with marriage, child rearing, family relationships and other aspects of life which are fundamental and implicit in the concept of ordered liberty.<sup>196</sup>

In concert with this view, the District Court of Hawaii in *Hawaii Psychiatric Society, District Branch of the American Psychiatric Association v. Ariyoshi*<sup>197</sup> held that, "No area could be more deserving of [constitutional] protection than communi-

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188. *Prince v. Massachusetts*, 321 U.S. 158 (1944).

189. *Pierce v. Soc'y of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

190. *Roe v. Wade*, 410 U.S. 113.

191. *Carey*, 431 U.S. at 684.

192. *Whalen*, 429 U.S. 589 (1977).

193. *Id.* at 598-600. See *Ariyoshi*, 481 F. Supp. at 1038.

194. *Smith*, *supra* note 180, at 22.

195. *Id.*

196. Some level of mental health is necessary for the exercise of even the most basic constitutionally guaranteed freedoms. As noted in *Rogers v. Okin*, the ability to control one's thoughts and coherently express oneself "is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection." 478 F. Supp. 1342, 1367 (D. Mass. 1979).

One might argue that interference with the effectiveness of one's psychotherapy and therefore with one's mental health is in actuality an intrusion into an "essential" rather than "fundamental" interest such that even a compelling state interest does not provide adequate justification.

197. 481 F. Supp. 1028.

cations between a psychiatrist and his patient.”<sup>198</sup> *Ariyoshi*, a 1979 case, involved an action brought by psychotherapists seeking to enjoin the enforcement of a Hawaii statute which authorized the issuance of administrative inspection warrants to search the offices and records of Medicaid providers.<sup>199</sup> Plaintiffs in *Ariyoshi* argued that the Hawaii statute was unconstitutional on its face in that it permitted an unwarranted intrusion into the privacy rights of their patients.<sup>200</sup>

Holding that the constitutionally protected right of privacy does indeed extend to an individual's liberty to make decisions regarding psychiatric care without unjustified interference,<sup>201</sup> the court stated: “An individual's decisions whether or not to seek the aid of a psychiatrist, and whether or not to communicate certain personal information to that psychiatrist, fall squarely within the bounds of this ‘cluster of constitutionally protected choices.’ ”<sup>202</sup>

Having recognized that the right to make decisions regarding psychiatric care is indeed fundamental, and therefore protected under the constitutional right of privacy,<sup>203</sup> the *Ariyoshi* court noted that the state's infringement of that right triggered the compelling state interest test.<sup>204</sup> “This court's inquiry, therefore, must be whether [the Hawaii statute] burdens the individual's liberty to make decisions regarding psychiatric care, and, if so, whether the State has demonstrated that the statute represents the least restrictive means to achieve a compelling state interest.”<sup>205</sup>

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198. *Id.* at 1038.

199. *Id.* at 1029. The issuance of inspection warrants was authorized pursuant to 1978 Hawaii Sess. Laws 105 (repealed 1981).

200. *Ariyoshi*, 481 F. Supp. at 1035.

201. *Id.* at 1039.

202. *Id.* at 1038 (quoting *Carey*, 431 U.S. at 685).

203. *Ariyoshi*, 481 F. Supp. at 1039. See also *Caesar v. Mountanos*, 542 F.2d 1064, 1069 (9th Cir. 1976); *Lora v. Board of Educ.*, 74 F.R.D. 565, 570-71 (E.D.N.Y. 1977); *In re B*, 482 Pa. 471, 484, 394 A.2d 419, 425 (1978).

204. *Ariyoshi*, 481 F. Supp. at 1039.

205. *Id.*

b. *Significant Government Interference*

A second prerequisite to invoking constitutional protection under the right of autonomy is for government action to interfere significantly with the ability of an individual to make decisions concerning fundamental issues.<sup>206</sup> Incidental or minor impediments do not result in an unconstitutional invasion of privacy.<sup>207</sup>

State action which places a significant burden on the exercise of the right of autonomy may be unconstitutional, even if protected choices are not entirely foreclosed by that action.<sup>208</sup> In 1977, the Supreme Court, in *Carey v. Population Services International*,<sup>209</sup> held that a New York statute, which limited to licensed pharmacists the ability to sell contraceptives, was in effect limiting access to contraceptives and therefore was an unconstitutional burden on the fundamental right to make decisions regarding childbearing.<sup>210</sup> In a companion case to *Roe v. Wade*,<sup>211</sup> the Supreme Court, in *Doe v. Bolton*,<sup>212</sup> struck down a Georgia statute requiring that abortions be performed only in accredited medical facilities. The Court reasoned that such a restriction limited, in a variety of ways, a woman's access to abortions and, therefore, imposed an unconstitutional burden on a woman's right to choose to have an abortion.<sup>213</sup>

In *Danforth*, the Supreme Court held that a Missouri statute requiring the reporting and recordkeeping of information concerning abortions was not an unconstitutional burden on the abortion rights of women so long as the state ensures that the reported information will not be publicly disclosed.<sup>214</sup> Similarly, in *Whalen*,<sup>215</sup> the Court upheld the constitutionality of a state system of reporting and recording prescriptions of certain fre-

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206. *Roe v. Wade*, 410 U.S. at 155-56.

207. *Smith*, *supra* note 180, at 22.

208. *Ariyoshi*, 481 F. Supp. at 1039.

209. *Carey*, 431 U.S. 678.

210. *Id.* at 686-91.

211. *Roe v. Wade*, 410 U.S. 113.

212. *Doe v. Bolton*, 410 U.S. 179 (1973).

213. *Id.* at 193-95.

214. *Danforth*, 428 U.S. at 79-81 (1976). *See supra* notes 163-66 and accompanying text.

215. *See supra* notes 167-75 and accompanying text.

quently abused medications.<sup>216</sup>

Although there appears to be no clear and distinct line separating an insignificant nuisance from an unconstitutional burden on the right of privacy, the above cases do provide some guidance. In those cases in which the state action was declared unconstitutional, the state action somehow limited or made more difficult the actual exercise of the fundamental right at issue.<sup>217</sup> In *Carey*, for example, the New York statute limited the accessibility of contraceptives, the opportunity for privacy of purchase and the possibility of price competition.<sup>218</sup> Similarly in *Bolton*, the Georgia statute resulted in actual limitation of access to facilities which carry out abortions.<sup>219</sup>

Unlike the statutes in *Carey* and *Bolton*, the reporting statutes held constitutional in *Danforth* and *Whalen* did not physically impair or limit the exercise of fundamental rights.<sup>220</sup> The Court's failure to strike down the statutes at issue may be explained by the fact that the scheme for reporting the performance of abortions and the prescribing of controlled medications were unlikely to affect the decisions of persons of ordinary sensitivity.<sup>221</sup> This distinction may also account for the Court's emphasis in both *Whalen* and *Danforth* on the presence of security arrangements<sup>222</sup> designed to prevent unwarranted public dissemination of private information.<sup>223</sup> Indeed, the presence of these safeguards may well have convinced the Court that the record-keeping requirements would not affect the quality of medical

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216. *Whalen*, 429 U.S. at 603-04.

217. *See Carey*, 431 U.S. at 687-88; *Bolton*, 410 U.S. at 192-200.

218. *Carey*, 431 U.S. at 689.

219. *Bolton*, 410 U.S. at 192-200.

220. *Whalen*, 429 U.S. at 603-04; *Danforth*, 428 U.S. at 79-81.

221. *Whalen*, 429 U.S. at 602-04. *See also Smith*, *supra* note 180, at 24.

222. *See Whalen*, 429 U.S. at 594-95; *Danforth*, 428 U.S. at 81. *See generally supra* note 90 and accompanying text (noting similar emphasis placed on the existence of security arrangements in decisions dealing with the psychotherapist-patient privilege).

223. The existence of government safeguards designed to protect subpoenaed psychiatric records from unnecessary additional disclosure is a factor in assessing the degree of interference with a patient's fundamental right of privacy. Some psychotherapists faced with compelled disclosure of their records have asserted that, irrespective of whether the confidential information is disclosed to the general public, disclosure to the State, in and of itself, is an impermissible intrusion into individual privacy rights. *See Ariyoshi*, 481 F. Supp. at 1041. *See supra* note 116 and *infra* notes 295-314 and accompanying text.

services or deter persons of ordinary sensitivity from seeking such services.<sup>224</sup>

In applying this reasoning to the issue of compelled disclosure of psychiatric records, it is imperative to note the dissimilar nature of the threat to privacy involved in the disclosure to a state of information regarding abortions or the use of prescription drugs and the disclosure of psychotherapeutic records. Certainly, the insult to one's privacy resulting from a disclosure of one's psychiatric records or even the disclosure that one is receiving psychiatric treatment is far greater than that which occurs when a state collects other types of medical information.<sup>225</sup>

Psychiatric literature reveals that potential breaches in the confidences of psychotherapy tend to cause both a disinclination to enter therapy and a loss of effectiveness of psychotherapy due to the withholding of information.<sup>226</sup> As such, government action which compels the disclosure of psychotherapeutic records would appear to significantly interfere with a person's fundamental right to choose whether or not to undergo therapy and disclose deeply personal information.<sup>227</sup>

### c. *Compelling State Interest*

The fact that a fundamental right has been significantly intruded upon does not, of itself, compel automatic elimination of the offending state action. A fundamental interest may be obstructed or regulated if there exists a "sufficiently compelling state interest."<sup>228</sup>

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224. *Whalen*, 429 U.S. at 603-04. See also *McKenna v. Fargo*, 451 F. Supp. 1355, 1381 (D.N.J. 1978).

225. See *infra* notes 264-93 and accompanying text. See *supra* note 116.

226. See *supra* notes 39-43 and accompanying text. "The few courts that have addressed the issue have assumed that disclosure of communications between an identifiable patient and his psychiatrist would deter individuals from seeking care and impair the therapy process itself." *Ariyoshi*, 481 F. Supp. at 1039. See also *Caesar*, 542 F.2d at 1067; *Lora*, 74 F.R.D. at 570-71.

227. The compelled production of psychiatric records which do not include confidential communications would be less likely to cause a disinclination to enter therapy and therefore would pose a substantially diminished intrusion into the right of autonomy.

228. *Carey*, 431 U.S. at 686. For example, the protection of a viable fetus is a compelling state interest that justifies certain state limitations on a woman's right to have an abortion. *Roe v. Wade*, 410 U.S. at 153-56.



The Supreme Court has not yet articulated specific guidelines for what constitutes a compelling state interest.<sup>229</sup> The Court, however, has identified three general categories of compelling interests, the furtherance of which have justified infringement upon fundamental rights.<sup>230</sup> These are: preventing the violent overthrow of the government,<sup>231</sup> preserving democracy,<sup>232</sup> and resolving clashes between conflicting fundamental rights.<sup>233</sup> This list is not exhaustive. On numerous occasions, the Supreme Court has upheld the constitutionality of a state intrusion into a fundamental interest when the state action did not involve one of these enumerated state interests.<sup>234</sup> In *Branzburg v. Hayes*,<sup>235</sup> for example, the Court held that fundamental first amendment rights did not relieve a journalist from his obligation to respond to a grand jury subpoena and to answer questions relevant to a criminal investigation.<sup>236</sup> The *Branzburg* Court described "[f]air and effective law enforcement" as a "fundamental function of government."<sup>237</sup> In *Caesar v. Mountanos*,<sup>238</sup> the United States Court of Appeals for the Ninth Circuit specifically held that "[t]he state has a compelling interest to insure that truth is ascertained in legal proceedings in its courts of law."<sup>239</sup> The court noted that this state interest has been held sufficient

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229. See generally, Note, *Of Interests, Fundamental and Compelling: The Emerging Constitutional Balance*, 57 B.U.L. REV. 462, 479 (1977).

230. *Id.*

231. See, e.g., *Korematsu v. United States*, 323 U.S. 214 (1944) (upholding wartime detention of persons of Japanese ancestry during World War II).

232. See, e.g., *Buckley v. Valeo*, 424 U.S. 1 (1976) (per curiam) (limiting campaign contributions, thereby insuring proper operation of democratic processes).

233. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (right of a woman to terminate her pregnancy conflicted with state interest in preserving the life of a viable fetus).

234. See Note, *supra* note 229, at 486-93.

235. *Branzburg v. Hayes*, 408 U.S. 665 (1972).

236. *Id.* at 690-91.

237. *Id.* at 690. This philosophy was reiterated by the Supreme Court in *United States v. Nixon*: "The need to develop all relevant facts in the adversary system is both fundamental and comprehensive. . . . The very integrity of the judicial system . . . depend[s] on full disclosure of all the facts, within the framework of the rules of evidence." 418 U.S. 683, 709 (1973). See also *United States v. Bryan*, 339 U.S. 323, 331 (1949).

238. 542 F.2d 1064.

239. *Id.* at 1069. In *Caesar*, the court considered a psychiatrist's refusal to obey a court order directing him to answer questions relating to communications with a former patient, who was the plaintiff in an action involving physical and psychological injuries following a motor vehicle accident. *Id.* at 1065.

to require newsmen to testify concerning privileged communications,<sup>240</sup> to compel testimony from witnesses who have invoked the fifth amendment privilege against self incrimination, once immunity has been granted,<sup>241</sup> and to compel testimony before a grand jury, concerning illegally obtained evidence.<sup>242</sup> In addition to the state interest in acquiring all relevant evidence in criminal proceedings, it has been held that the state also has a "compelling interest in ensuring that services and supplies for which it is being billed have been provided, and that the medicaid program is not being defrauded."<sup>243</sup>

Thus, although compelled production of psychiatric records may be a significant intrusion into the fundamental rights of a patient, there does exist a compelling state interest which may validate the state's intrusion into these fundamental rights. Once the state interests in the fair administration of criminal justice and the protection of the integrity of the Medicaid program are identified as compelling, the next stage of the constitutional analysis is a determination of whether a state can demonstrate that its actions are both necessary and the least restrictive means possible to achieve its compelling interest.<sup>244</sup>

#### *d. Necessity of State Action and Least Restrictive Alternative*

The scope of the government's right to legislate in areas of fundamental individual rights depends not only on the compelling nature of its interest but also on the means employed in furtherance of that interest. For a state intrusion into a fundamental right to be legitimate, it must be as limited and as narrowly drawn as possible and must be the least restrictive alter-

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240. *Id.* at 1069 (citing *Branzburg v. Hayes*, 408 U.S. 665 (1972)).

241. *Caesar*, 542 F.2d at 1069 (citing *Kastigar v. United States*, 406 U.S. 441 (1972)).

242. *Caesar*, 542 F.2d at 1069 (citing *United States v. Calandra*, 414 U.S. 338 (1974)). See generally *Murphy v. Waterfront Comm'n*, 378 U.S. 52, 93-94 (1964) (White, J., concurring) (describing the "broad" power of the state to compel residents to testify in court or before grand juries as "[a]mong the necessary and most important").

243. *Ariyoshi*, 481 F. Supp. at 1041. See also *Schnaubman v. Blum*, 49 N.Y.2d 375, 379-80, 402 N.E.2d 1133, 1135, 426 N.Y.S.2d 230, 233 (1980) (describing the honest management of the Medicaid system as an "important public interest").

244. *Roe v. Wade*, 410 U.S. at 155.

native available to advance the compelling state interest.<sup>245</sup>

In the context of Medicaid fraud investigations, federal law provides explicit guidance as to the degree of disclosure of medical records actually necessary to advance the state's interest in protecting the integrity of the Medicaid program. The applicable federal statute establishes a relatively narrow disclosure standard, requiring the disclosure of medical records only to the extent necessary to document the actual deliverance of Medicaid-reimbursed services.<sup>246</sup>

Acknowledging the narrow disclosure standard delineated in the federal Medicaid statute, the District Court of Hawaii, in *Ariyoshi*, specifically considered the degree of intrusion into psychiatric records which would be necessary for the investigation of Medicaid fraud and therefore constitutionally permissible. The court held that there was "no evidence that review by the State of personal and confidential information contained in a psychiatrist's patient files is necessary to prevent fraud. The details of a patient's problems are not necessary to an evaluation of whether a psychiatrist is rendering services in the amount claimed."<sup>247</sup>

Holding that the disclosure of confidential psychotherapeutic communications was not necessary for effective oversight of

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245. *Id.*; See also *Griswold*, 381 U.S. at 485; *Carey*, 431 U.S. at 686.

246. The federal statute dealing with maintenance and disclosure of records by Medicaid providers requires each state Medicaid plan to:

provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or Secretary may from time to time request.

42 U.S.C. § 1396a(a)(27) (1982).

Under the federal regulation promulgated to implement this statute, each state Medicaid plan must require providers of medicaid services to agree to:

(1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients; [and] (2) On requests, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit (if such a unit has been approved by the Secretary under § 455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan.

42 C.F.R. § 431.107(b) (1985).

247. *Ariyoshi*, 481 F. Supp. at 1041-42.

the Medicaid program, the *Ariyoshi* court looked to the existence of less intrusive means of achieving the state interests.<sup>248</sup> Specifically, the court described a procedure in which psychotherapists, whose records were being sought by investigators, could review their files and delete those portions which contain confidential matters.<sup>249</sup> If, based on a review of the redacted records, state investigators determined that a reasonable suspicion existed that a provider was defrauding the state, a warrant to inspect more sensitive records might then be available.<sup>250</sup> The court found that the availability of such less burdensome alternatives for achieving the state interest<sup>251</sup> in controlling Medicaid fraud cast "considerable doubt" on the constitutionality of the Hawaii statute.<sup>252</sup>

Indeed, regarding investigations into the length and frequency of treatment and the identity of the participants, notations made by a therapist in his progress notes are unlikely to reveal greater significant information than the contents of appointment books and time and billing records.<sup>253</sup> In addition, as

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248. *Id.* at 1042.

249. *Id.*

250. *Id.* Although such a program appears on its face to fulfill the needs of the state, a valid argument can be made that any redaction of records performed by a psychotherapist who is the target of an investigation can reasonably be expected to result in suppression of both patient communications and any incriminating materials.

251. *Id.* Such less intrusive means have been described in greater detail by other courts. See *supra* note 72. See also Smith, *supra* note 180, at 36.

252. *Ariyoshi*, 481 F. Supp. at 1042. Note that the statute at issue in this case called for the issuance of administrative inspection warrants to search the offices and records of Medicaid providers. *Id.* at 1029.

253. The range of communications relevant to legitimate psychotherapy is so broad that, as a practical matter, very little information useful to a Medicaid billing investigation can be gleaned from notes generally made by psychotherapists. Long periods of silence, monologue by the patient, dialogue between patients or patient and therapist are common and are therapeutically appropriate. Records of such communications are rarely uniform, far from complete and therefore have little, if anything, to do with inquiries as to billing accuracy. See Slovenko, *On the Need for Recordkeeping in the Practice of Psychiatry*, 7 J. PSYCHIATRY & L. 399, 403 (1979) (acknowledging the existence of nearly 200 forms of psychotherapy). See generally L. KOLB, *MODERN CLINICAL PSYCHIATRY* 767-804 (1977).

It is significant to note that the federal Medicaid statutes require the production of records to disclose fully the *extent* of services provided rather than the quality or medical necessity of the services. If quality or necessity were at issue, then perhaps compelled production of records containing the essentials of the therapeutic session would be justified.

Commenting on this, the *Ariyoshi* court noted: "[T]he state has no more interest in

protections for the confidences of therapy diminish, patients can be expected to withhold information from therapists,<sup>254</sup> and therapists faced with possible disclosure of their files may tend to keep scantier records so as to protect their patient's confidentiality.<sup>255</sup> Paradoxically, therefore, by coercing the revelation of therapeutic communications, state action ostensibly designed to enhance the availability of probative evidence may counterproductively effectuate the removal from psychiatric records of the very information originally sought by the state. Thus, it can hardly be argued that state action which may actually impede the availability of evidence is either necessary to or the least restrictive possible method of securing all available evidence.

In evaluating whether a state action which compels the production of psychiatric records is the least restrictive alternative, paramount consideration should be given to the presence or absence of safeguards designed to prevent unnecessary disclosure.<sup>256</sup> Surely, a state Medicaid investigating scheme which fails to safeguard the confidentiality of private records cannot be considered the least restrictive means possible and therefore is unlikely to withstand a constitutional challenge.<sup>257</sup>

It appears therefore, that compelled disclosure of full psychiatric records, including patient communications and therapist

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ensuring the quality of care provided Medicaid beneficiaries than that provided patients who pay. The states have uniformly chosen to pursue that interest by regulating the licensing of medical practitioners and medical facilities." *Ariyoshi*, 481 F. Supp. at 1042. See also Perlman & Schwartz, *Medical Records and the Psychiatric Private Sector*, 137 AM. J. PSYCHIATRY, 1586, 1587 (1980); Perlman, Schwartz, Paris, Thornton, Smith & Weber, *Psychiatric Records: Variations Based on Discipline and Patient Characteristics, with Implications for Quality of Care*, 139 AM. J. PSYCHIATRY 1154, 1155-56 (1982).

One authority has suggested that the evidentiary requirements of relevancy and materiality provide the best protection against unnecessary disclosure of confidential psychotherapeutic records. "[T]he confidentiality of a physician-patient or psychotherapist-patient communication is protected from disclosure in a courtroom only by a showing that the communication would have no relevance or materiality to the issues in the case." Slovenko, *Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope*, 23 CATH. U.L. REV. 649, 659 (1974).

254. See *supra* note 41.

255. See *supra* notes 44-45 and accompanying text.

256. See *supra* notes 89-90, 116-17, 131 and accompanying text.

257. See Smith, *supra* note 180, at 36. "[F]ailure to safeguard against unnecessary intrusions into . . . privacy raises serious doubts whether these jurisdictions can legitimately rely on the compelling state interest in obtaining all relevant testimony to justify an interference with the privacy of therapy." *Id.*

observations, is not the least restrictive means available to fully disclose the extent of services provided by psychotherapists participating in the Medicaid program. The production of appointment books, billing records and other fragmentary data would appear to be minimally restrictive and sufficiently effective to satisfy fully the Medicaid program's statutory requirements.<sup>258</sup>

e. *Balancing Competing Interests*

Even if it can be demonstrated that a state action meets each of the previous criteria, the compelling state interest test requires a balancing of the benefits to the state interest against the "extent of the burden that they place on individual rights."<sup>259</sup> In such a balancing test, governmental action which is necessary to the advancement of a compelling state interest, at only a minimal cost to a fundamental right, will likely pass constitutional muster. State action, however, which only minimally advances a compelling state interest at a significant cost to a fundamental right is unlikely to receive constitutional approbation.<sup>260</sup>

This balancing analysis is substantially similar to that used by most courts adjudicating claims based on the psychotherapist-patient privilege.<sup>261</sup> Once again, in the context of Medicaid fraud investigations, factors which are often determinative in such a balancing analysis are the nature and degree of intrusiveness of the requests for information and the presence or absence of state guarantees of continued confidentiality.

f. *Conclusion of Autonomy Analysis*

Thus, under the autonomy strand of the right of privacy, it is likely that in an adjudication of a psychotherapist's challenge to compelled production of records pursuant to an investigation of Medicaid fraud courts will reach conclusions similar to those reached in *Kobrin*<sup>262</sup> and other cases which utilized a balancing

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258. See *supra* notes 246-47 and accompanying text.

259. *Buckley*, 424 U.S. at 68.

260. For a detailed analysis of this balancing approach, see Note, *supra* note 229, at 493-94.

261. See *supra* notes 91-119 and accompanying text.

262. See *supra* notes 107-19 and accompanying text.

approach to determine the applicability and scope of the psychotherapist-patient privilege. When subpoenaed records are limited to those containing only fragmentary data<sup>263</sup> such as appointment books and billing and time records, and when there exist safeguards against further, unnecessary disclosure, courts are likely to find that the limited intrusion into the privacy rights of the patient will be outweighed by the state's need to investigate suspected Medicaid fraud. When, however, the records sought are more detailed psychological profiles or accounts of patient communications, or where the continued confidentiality of the psychiatric record is not somehow protected, courts will be more likely to find the state action to be a constitutionally impermissible intrusion into individual autonomy rights.

## 2. *Right of Informational Privacy*

The second element of the right of privacy identified by the Supreme Court in *Whalen* is the right to avoid the disclosure of personal matters.<sup>264</sup> This right of "informational privacy" protects confidential information which a person generally does not release to others except for the most compelling of reasons.<sup>265</sup>

### a. *Informational Privacy in Psychotherapy*

In this regard, no information can be more intensely personal and confidential than that contained in the files of a psychotherapist.<sup>266</sup> Because of the intimate nature of the subject matter of psychotherapy,<sup>267</sup> patients undergoing treatment usu-

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263. See *supra* note 117 and accompanying text.

264. *Whalen*, 429 U.S. at 599.

265. This kind of information has been described as that "which a person desires to keep private and which, if disseminated, would tend to cause substantial concern, anxiety or embarrassment to a reasonable person." Leigh, *Informational Privacy: Constitutional Challenges to the Collection and Dissemination of Personal Information by Government Agencies*, 3 HASTINGS CONST. L.Q. 229, 251 (1976).

266. See *supra* notes 37-39 and accompanying text. See also Ariyoshi, 481 F. Supp. at 1043; L. KOLB, *supra* note 253, at 767-804.

267. Psychotherapy deals not only with an exchange of information between patient and psychotherapist, but also with the patient's most intimate self, his dreams, his fears, and quite often subjects of such intensity that they have been relegated to the subconscious. Because of the unique nature of the psychotherapist-patient relationship, patients often disclose information to their therapists that they would not reveal to others.

ally have a high expectation that the information they reveal will be kept confidential.<sup>268</sup> It has been held that such an interest in keeping confidential revelations from public purview "draws sustenance from our constitutional heritage."<sup>269</sup> Thus, psychotherapeutic communications and records containing such communication demand constitutional protection under the right of informational privacy.<sup>270</sup>

b. *Standard of Review*

The Supreme Court has yet to provide explicit guidance as to the proper standard of review to be applied under the informational privacy strand of the general right to privacy.<sup>271</sup> In *Whalen*, however, the Court implicitly utilized a balancing standard in upholding the New York State drug prescription reporting statute. The Court weighed the societal interests served by the statute against the degree and effect of the intrusion into individual privacy interests caused by enforcement of the statute.<sup>272</sup>

In *Nixon v. Administrator of General Services*,<sup>273</sup> the Supreme Court considered former President Nixon's challenge to a federal statute which permitted professional archivists to screen presidential papers. Acknowledging that Nixon had a legitimate informational privacy interest in portions of the material in question, the Court balanced the competing interests for and against disclosure and upheld the enforcement of the federal

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See also *Caesar*, 542 F.2d 1064. "Communications between a patient and his or her psychotherapist often involve intimate medical problems of family, marriage, motherhood and fatherhood, human sexuality, and almost always concern strong emotional needs of the patient." *Id.* at 1072.

268. See generally *Katz v. United States*, 389 U.S. 347, 351-53 (1967) (In determining extent of privacy interests, the reasonable expectation of privacy is of utmost significance). See also Meyer & Smith, *A Crisis in Group Therapy*, 38 AM. PSYCHOLOGIST 638, 639 (1977) (84% of subjects in the study assumed that confidentiality in psychotherapy included a refusal to testify about a patient even if validly ordered to do so by a court of law).

269. *In re Lifschutz*, 2 Cal. 3d 415, 431, 467 P.2d 557, 567, 85 Cal. Rptr. 829, 839 (1970).

270. *Ariyoshi*, 481 F. Supp. at 1043. *Contra* *J.P. v. Desanti*, 653 F.2d 1080 (6th Cir. 1981) (no constitutional right protects non-disclosure of juveniles' social histories).

271. *Ariyoshi*, 481 F. Supp. at 1043.

272. *Whalen*, 429 U.S. at 600-03.

273. 433 U.S. 425 (1977).



statute.<sup>274</sup>

Explicit guidance regarding the adjudication of claims under the constitutional right of informational privacy has been provided by the Fifth Circuit in *Plante v. Gonzalez*.<sup>275</sup> Upholding financial disclosure laws for certain public officials, the court held that when the right to privacy is invoked to protect confidential information, a balancing standard is appropriate.<sup>276</sup> The court contrasted this to the right of autonomy which, when invoked, triggers a compelling state interest analysis.<sup>277</sup> The court stressed that in applying this balancing standard, a constitutional right is at stake and therefore, "more than mere rationality must be demonstrated . . ." to justify a state intrusion.<sup>278</sup>

The balancing approaches of *Nixon* and *Plante* have been adopted by courts adjudicating informational privacy claims involving the release of psychological information in the screening of job applicants,<sup>279</sup> and the disclosure of psychotherapeutic communications in a criminal trial.<sup>280</sup> In *Ariyoshi*,<sup>281</sup> the Hawaii District Court directly considered the proper standard of review under the right of informational privacy as applied to an investigation of a psychiatrist's Medicaid billing practices.<sup>282</sup> The *Ariyoshi* court held that "the appropriate test under the confidentiality strand of the privacy right . . . is to balance the state interests served . . . against the intrusion into an individual's privacy."<sup>283</sup> In such a balance test, however, because of the

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274. *Nixon*, 433 U.S. at 442-48. The statute at issue was the Presidential Recordings and Materials Preservation Act, 44 U.S.C. § 2107 (1982) (current version at 44 U.S.C. § 2107 (1986)). Factors included in the Court's balancing analysis were the limited nature of the intrusion, the impossibility of separating personal material from public documents and the magnitude of the public interest involved.

275. 575 F.2d 1119 (5th Cir. 1978).

276. *Id.* at 1134.

277. *Id.*

278. *Id.*

279. See *McKenna v. Fargo*, 451 F. Supp 1355 (D.N.J. 1978) (assessing the constitutionality of psychological testing used by Jersey City to screen fire department applications).

280. See *Cesar*, 542 F.2d 1064 (involving an appeal from contempt proceedings following a refusal to obey a court order directing a psychiatrist to answer questions regarding communications with a former patient who was a defendant in a criminal proceeding).

281. *Ariyoshi*, 481 F. Supp. 1028.

282. *Id.* at 1043.

283. *Id.*

highly sensitive nature of the protected zone of privacy, a burdensome regulation may only be justified by a compelling state interest.<sup>284</sup> This therefore places a "great weight on the privacy end of the traditional balancing test."<sup>285</sup>

Similarly, in *In re Zuniga*,<sup>286</sup> the Sixth Circuit applied a balancing analysis in a case involving a psychiatrist's claim that his patient files, subpoenaed in a grand jury investigation of billing fraud, were protected by his patient's rights of informational privacy.<sup>287</sup> Assuming arguendo the existence of such a right, the court balanced the limited nature of the intrusion<sup>288</sup> against the "need for the grand jury to conduct an effective and comprehensive investigation into [an] alleged violation of the law."<sup>289</sup> The court concluded that the enforcement of the subpoenas did not unconstitutionally infringe upon the rights of the involved patients.<sup>290</sup>

As in the final analysis of the autonomy strand of the right of privacy, the appropriate standard of review under the informational strand is a balancing standard.<sup>291</sup> This standard is closely analogous to the balancing approach utilized by courts adjudicating claims under the psychotherapist-patient privilege.<sup>292</sup> Therefore, as the intrusion into the right of informational privacy increases (by virtue of the character of the information sought and the likelihood of unnecessary disclosure) so

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284. *Id.*

285. *Id.*

286. *In re Zuniga*, 714 F.2d 632 (6th Cir. 1983). See *supra* notes 73-89 and accompanying text.

287. *Zuniga*, 714 F.2d at 641.

288. See *supra* notes 85-90 and accompanying text.

289. *Zuniga*, 714 F.2d at 642.

290. *Id.*

291. See *supra* text accompanying notes 275-90. See also *Fadjo v. Coon*, 633 F.2d 1172, 1176 (5th Cir. 1981) ("An intrusion into the interest in avoiding disclosure of personal information will thus only be upheld when the government demonstrates a legitimate state interest which is found to outweigh the threat to the plaintiff's privacy interest.").

292. Although closely analogous, the balance tests are distinguishable. Unlike privilege cases, courts adjudicating constitutional privacy issues first address the threshold question of whether the interest advanced by the state action is compelling.

In the context of Medicaid fraud investigations, however, this distinction is inconsequential. In all privacy cases it has been held that the interests of the state in maintaining the integrity of the Medicaid program and in the fair administration of criminal justice are compelling.

too will the burden on the state to justify such an intrusion.<sup>293</sup>

Thus, under the informational strand of the constitutional right of privacy, the outcome of cases involving the investigation of suspected Medicaid fraud on the part of psychotherapists will likely be identical to those cases decided under the autonomy strand of the constitutional right or the psychotherapist-patient evidentiary privilege. When subpoenaed records include detailed psychological profiles or patient communications, or when the threat of additional unnecessary disclosure of the records is great, courts will likely find the state interest in obtaining those records to be outweighed by the individual's interest in maintaining confidentiality. When on the other hand, the subpoenaed records are limited to those containing only fragmentary data, and there exist safeguards against further disclosure of the records, the state's interests in the fair administration of justice and in maintaining the integrity of the Medicaid program will likely outweigh the limited intrusion into the informational privacy interests of the patient.

#### IV. Safeguards Against Disclosure of Confidential Information

##### A. General Federal Regulations

In the context of subpoenaed psychiatric records, a significant factor in the determination of the scope and effect of the psychotherapist-patient privilege and the constitutional right of privacy is the presence of safeguards designed to protect subpoenaed information from further, unnecessary disclosure. In this regard, governmental access to and use of private information has received considerable legislative attention in the recent past. On the federal level, two pieces of legislation, the Freedom of Information Act (FOIA)<sup>294</sup> and the Privacy Act of 1974<sup>295</sup> both affect individual privacy interests in medical records held by governmental agencies.

While the purpose of the FOIA is generally to permit public access to federal records,<sup>296</sup> the Act also specifies exemptions for

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293. See *infra* text accompanying notes 259-61.

294. 5 U.S.C.A. § 552 (West 1977 & Supp. 1985).

295. 5 U.S.C.A. § 552a (West 1977 & Supp. 1985).

296. H.R. Rep. No. 1497, 89th Cong., 2d Sess. 1, (reprinted in 1966 U.S. CODE CONG. & AD. NEWS 2418). See generally *Department of the Air Force v. Rose*, 425 U.S. 352

certain materials such as those relating to national security, trade secrets, and personal and medical files "the disclosure of which would constitute an unwarranted invasion of personal privacy."<sup>297</sup> These statutory exemptions are narrowly construed so as to effectuate the legislative intent.<sup>298</sup> If this medical record exception to the FOIA is found to apply, protections enunciated in the Privacy Act of 1974 then take effect.<sup>299</sup>

The language of the Privacy Act of 1974 indicates that an individual's right of privacy is both "personal and fundamental."<sup>300</sup> The Act, whose stated purpose, *inter alia*, is to "promote governmental respect for the privacy of citizens,"<sup>301</sup> requires government agencies which use or store personal information to comply with privacy mandates, including a strict prohibition against disclosure of the information.<sup>302</sup> Failure to comply with the provisions of the Privacy Act can result in both civil actions against the agency in possession of the information<sup>303</sup> and criminal penalties against the officer or employee who willfully discloses the information.<sup>304</sup>

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(1976).

297. 5 U.S.C.A. § 552(b)(6) (West 1977 & Supp. 1985).

298. When a party makes a FOIA request for a medical file held by a government agency, the agency must determine: first, if the material is indeed a medical file and thus governed by the medical records exception; and, second, assuming it is excepted, whether disclosure would constitute an unwarranted invasion of individual privacy interests. *See, e.g., Washington Post v. Department of Health and Human Servs.*, 690 F.2d 252, 260 (D.C. Cir. 1980).

Agency refusal to disclose is subject to judicial review in the federal district court. In such cases, courts undertake the same two step analysis performed by the agency. If, however, the agency grants disclosure, the individual who is the subject of the medical record may bring an action in federal district court to preclude disclosure. *See Consumers Union v. Consumers Prod. Safety Comm'n*, 590 F.2d 1209, 1215 nn.27-28 (D.C. Cir. 1978), *rev'd on other grounds, sub. nom G.T.E. Sylvania, Inc. v. Consumers Union of the United States, Inc.*, 445 U.S. 375 (1980).

299. 5 U.S.C.A. § 552(b)(6) (West 1977 & Supp. 1985).

300. 5 U.S.C.A. § 552a (West 1977 & Supp. 1985).

301. S. Rep. No. 1183, 93d Cong., 2d Sess. 1, *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 6916.

302. *Id.* Under the Privacy Act, agencies are not permitted to disclose information about an individual even to another government agency without the individual's written consent. One exception to this prohibition, however, is a permitted release of information necessary for law enforcement activities.

*See* 5 U.S.C.A. § 552a(b)(7) (West 1977 & Supp. 1985).

303. 5 U.S.C.A. § 552a(g)(1) (West 1977 & Supp. 1985).

304. 5 U.S.C.A. § 552a(i)(1) (West 1977 & Supp. 1985). A violation of provisions of the Privacy Act is a misdemeanor subjecting the violator to fines of up to \$5,000.

Thus, in the federal system, general safeguards, designed to prevent unnecessary disclosure of confidential records, do exist. In light of legislative intent to subject more federal records to public scrutiny, however, these general statutory safeguards do not appear to provide adequate protection to counterbalance the intrusiveness of certain compelled disclosures of psychiatric patient files in Medicaid fraud investigations.<sup>305</sup>

### B. Confidentiality in the Medicaid Program

In Medicaid fraud investigations, records are subpoenaed generally by either the State Medicaid Fraud Control Unit of the State Attorney General's Office<sup>306</sup> or a grand jury. Grand jury proceedings are secret<sup>307</sup> and any violation of that secrecy is a criminal offense.<sup>308</sup> Records retained by the State Medicaid Fraud Control Units are subject to federal regulations designed to "protect the privacy rights of [Medicaid] recipients."<sup>309</sup>

These regulations limit the release of medical information to "purposes directly connected with the administration of the [Medicaid] plan."<sup>310</sup> The types of information protected by these regulations include "at least-(1) Names and addresses; (2) Medical services provided; (3) Social and economic conditions or circumstances; (4) Agency evaluation of personal information; and (5) Medical data, including diagnosis and past history of disease

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305. In deciding whether or not to disclose medical records, government agencies balance the individual's interest in non-disclosure against the public interest in favor of disclosure. See *Washington Post*, 690 F.2d at 260. Mindful of the legislative intent behind the FOIA, toward disclosure rather than secrecy, courts have tipped the balance in favor of disclosure. *Id.* at 261. See also *Rose*, 425 U.S. at 361.

306. The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 provided for the establishment of state Medicaid Fraud Control Units to protect the program from fraudulent practices. 42 U.S.C.A. § 1396b(q) (West 1983 & Supp. 1985). Federal regulations require that when a fraud control unit determines that provider records may be useful in investigations of suspected fraud it shall have: "[a]ccess to any information kept by providers to which the agency is authorized access." 42 C.F.R. § 455.21(a)(2)(iii) (1985).

307. This is governed by state law. See, e.g., N.Y. CIV. PRAC. LAW § 190.25(4) (McKinney 1985). See also *In re Zuniga*, 714 F.2d 632, 642 (6th Cir. 1983) (acknowledging protection of records by the "veil of secrecy attending grand jury proceedings").

308. See, e.g., N.Y. CIV. PRAC. LAW § 215.70 (McKinney 1985).

309. 42 C.F.R. § 455.21(a)(2)(iii) (1985). See also 42 C.F.R. § 431.300-.307 (1985) (safeguarding information on applicants and recipients).

310. 42 C.F.R. § 431.301 (1985).

or disability.”<sup>311</sup> These regulations apply to all requests for information “including [those from] government bodies, the courts, or law enforcement officials.”<sup>312</sup>

Of course, once a suspected perpetrator of Medicaid fraud is brought to trial, the contents of all records admitted into evidence become a matter of public record. It is at trial, however, that courts adjudicating the cases may themselves provide safeguards against public disclosure of confidential information. Such safeguards may include in camera inspection, masking of patient identities through partial redaction of the records, protective orders and, at the conclusion of the case, sealing the file.<sup>313</sup>

Thus, although general federal regulations may not provide safeguards adequate to prevent unwarranted disclosure of confidential data, the regulations governing the investigation of Medicaid fraud, the laws governing the secrecy of grand jury proceedings and the broad powers of the court to fashion protective orders would appear to reduce substantially the intrusiveness of compelled disclosure of psychiatric records. Although substantially reduced, in the context of psychotherapeutic records, a balancing of this intrusiveness against the state’s interests in the administration of criminal justice and effective oversight of the Medicaid program will tip in favor of disclosure only if the records at issue do not contain sensitive patient communications or equally confidential material.

## V. Conclusion

In the context of Medicaid fraud investigations, psychotherapists claiming protection of their patient records by way of the constitutional right of privacy will acquire no greater degree of protection against compelled disclosure than those seeking to

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311. 42 C.F.R. § 431.305(b) (1985).

312. 42 C.F.R. § 431.306(e) (1985).

313. *See Carr v. Monroe Mfg. Co.*, 431 F.2d 384, 390 (5th Cir. 1970) (“[A] trial court is duty-bound, where it orders production of documents in which there are strong policy reasons against public disclosure, to limit the availability and use of those documents and their contents by carefully drawn protective provisions.”) *See also Lora v. Board of Educ.*, 74 F.R.D. 565, 582 (E.D.N.Y. 1977) (In addition to protective orders limiting use and access to confidential records, the court ordered redaction of all identifying data from the records).

shield their records via statutory and common law psychotherapist-patient evidentiary privileges.<sup>314</sup>

Courts inquiring as to the scope of the psychotherapist-patient privilege or the constitutional right of privacy will each conduct a balancing analysis of the probity of the evidence sought as weighed against the degree of intrusion into a patient's privacy interests.<sup>315</sup> Factors pertinent to such an inquiry are the nature and content of the records sought and the availability of safeguards designed to protect against unwarranted additional disclosure.<sup>316</sup>

In an inquiry of suspected Medicaid billing fraud, the content of psychotherapeutic communications yields little probative evidence that cannot be obtained elsewhere and at a lesser cost to individual privacy.<sup>317</sup> As such, demands for such records should not receive constitutional approbation. When records sought do not include such intimate information, the protections against unnecessary disclosure inherent in the Medicaid and the grand jury systems will be sufficient to tip the balance in favor of disclosure of such probative and minimally intrusive data.

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314. See *supra* notes 60-131, 262, 293 and accompanying text. The advantages of arguing the constitutional issue are not to be discounted, however. Constitutional privacy rights are permanent. They do not yield to local law nor can they be easily discarded by legislative enactments.

315. See *supra* notes 80-84, 111-13, 259-61 and accompanying text.

316. See *supra* notes 89-90, 117, 144-46, 245-58 and accompanying text.

317. See *supra* notes 247-53 and accompanying text.