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**SHOULD THERE BE A PSYCHOTHERAPIST PRIVILEGE
IN MILITARY COURTS-MARTIAL?**

A THESIS

Presented to

The Judge Advocate General's School, United States Army

The opinions and conclusions expressed herein are those of the author and do not necessarily represent the views of either the Judge Advocate General's School, The United States Army, or any other governmental agency.

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United States Army

36TH JUDGE ADVOCATE OFFICER GRADUATE COURSE

4 April 1988

SHOULD THERE BE A PSYCHOTHERAPIST PRIVILEGE

IN MILITARY COURTS-MARTIAL

by CPT DAVID L. HAYDEN, JAGC

ABSTRACT: This thesis examines whether a psychotherapist-patient privilege should exist in military courts-martial. The need for confidentiality and trust in the psychotherapeutic relationship merits further attention, despite the military bias against any medical privilege. This thesis concludes that a psychotherapist-patient privilege should exist in military courts-martial, in the form of either an army regulation or a new Military Rule of Evidence.

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SHOULD THERE BE A PSYCHOTHERAPIST PRIVILEGE IN MILITARY COURTS-MARTIAL?

I don't see where you people are going to stop. Pretty soon you won't have anybody left who can testify to anything. We will all be privileged classes, the privileged folks, and then there will be the common people who actually have to go to court and act like American citizens. We will all be chiefs, and no Indians. I think it is crazy...¹

I. INTRODUCTION

The statement illustrates the frustration most people share concerning rules of privilege. Privileges hinder admissibility of relevant evidence that could aid the fact-finder in ascertaining the ultimate truth.² Many modern commentators have described them as encumbrances, originating from competing professional jealousies, impeding the orderly pursuit of truth and serving no important societal goal.³ Nonetheless, testimonial privileges serve a useful purpose in preserving the sanctity of confidential relationships that must, in the public interest, be fostered and protected.⁴ Courts are forced to balance conflicting values when privileges are in issue. They must render an accurate and efficient decision, while attempting to protect the privacy and confidentiality of privilege claimants.⁵

The military justice system recognizes some testimonial privileges as rules of law.⁶ Nonetheless, certain privileges are outright rejected. The military has always held a strong antimedical privilege position.⁷ Any doctor-patient privilege was considered contrary to the military's interest in maintaining the health and welfare of its personnel.⁸ A recent Court of Military Appeals opinion, United States v. Toledo,⁹ reaffirmed that position.

In Toledo, a military judge allowed an Air Force psychologist to testify for the government in rebuttal concerning a previous noncompelled examination of the accused, despite defense objection on privilege grounds.¹⁰ The Court of Military Appeals held that the "Military Rules of Evidence recognize no doctor-patient privilege per se."¹¹ Absent from the decision was any reference to a psychotherapist privilege, due in large part no doubt, to the absence of any objection on that ground. The Court did identify the attorney-client privilege as an alternative for the defense to prevent disclosure of the psychologist's statements.¹² The issues identified by the Toledo Court will be analyzed later in this thesis.

It is essential at this point to identify and define the parameters of psychotherapy to assist in understanding the complexities of the issue. Psychotherapy involves the treatment by a psychotherapist of mental or emotional disorders, including drug and alcohol addiction.¹³ For the purposes of this thesis, a psychotherapist shall be (1) any person licensed to practice medicine in any state or nation who practices psychiatry all or part of the time or (2) any person licensed or certified as a psychologist under the laws of any state or nation who practices clinical psychology all or part of the time.¹⁴ The 1971 draft of the Proposed Federal Rules of Evidence, Rule 504, used a broader definition to include persons reasonably believed by the patient to be practicing psychiatry or clinical psychology. This was believed necessary because of the number of people who render similar psychotherapeutic aid but are not psychiatrists or psychologists.¹⁵ That definition creates many potential issues of interpretation and is an unnecessary expansion for purposes of the military.

The law of privilege should also be distinguished from confidentiality. A privilege rule allows an individual to prevent court ordered disclosure of certain communications. Confidentiality refers to a duty, normally an ethical restriction imposed by a professional code, not to engage in gratuitous disclosures of certain communications.¹⁶ The terms are often

used interchangeably, yet, they are distinct concepts. This thesis only addresses the law of privilege. The only confidential communications discussed will be those not intended for disclosure to third persons except when necessary for the patient's diagnosis and treatment.¹⁷

There should be a psychotherapist privilege in courts-martial. There is substantial precedent in federal common law and federal practice to support such a rule. Indeed, absent the antimedical privilege language in the Military Rules of Evidence, recognition pursuant to federal common law would be likely.¹⁸ Nonetheless, adoption of a psychotherapist-patient privilege in military courts is unlikely without a regulatory or executive mandate. Empirical data obtained from Army psychiatrists provides some insight, but, surprisingly mixed support for the psychotherapeutic privilege. The survey responses indicated little or no impact on army psychiatrist's practices from the lack of a privilege. The responses did not support assertions that the privilege would allow army psychiatrists to treat patients more effectively. After further analysis of the responses, however, the results may have been misleading. A closer look reveals the necessity for some form of a psychotherapist-patient privilege.

The purpose of this thesis is to address the issue of whether psychotherapists should be allowed any testimonial privilege in military courts-martial. The thesis will begin by exploring several theories currently used to justify existing privileges at common law, then apply them to the psychotherapist-patient privilege. This will be followed by a brief analysis of the development of the privilege under federal and state law. A study of the Proposed Federal Rule of Evidence, Rule 504, and the current Federal Rule of Evidence, Rule 501, will be included. Federal case law development of the privilege will also be traced, including federal statutes. This will be followed by a brief look at State laws creating similar privileges. Next, the thesis will cover the treatment of the privilege under the Military Rules of Evidence and military case

law. Finally, results of an empirical survey of army psychiatrists conducted as part of this thesis will be discussed.

II. HISTORICAL BASIS FOR PHYSICIAN-PATIENT PRIVILEGE

No doctor-patient privilege existed at common law.¹⁹ Lord Mansfield, addressing the issue at trial in England stated, "If a surgeon was voluntarily to reveal these secrets, to be sure, he would be guilty of a breach of honor 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."²⁰ Despite this eloquent discourse, variations of the privilege exist today by statute in many forums.²¹ The absence of historical precedent in the English or Federal common law has not deterred the states from creating numerous medically related privileges.²² Indeed, the common law may yet be disposed to recognize such a privilege.²³

A. THEORIES JUSTIFYING PRIVILEGES

1. The Utilitarian Analysis

Current theories advanced by privilege proponents normally fall within two basic categories. The first is the utilitarian theory.²⁴ The rationale begins by assuming that nondisclosure of information is not favored unless it furthers some social policy.²⁵ For example, the attorney-client privilege is accepted because it will encourage clients to be more forthright with their lawyers.²⁶ The privilege is analyzed in terms of how society is best served. The otherwise unfavorable privilege is tolerated when harm to the confidential relationship from disclosure outweighs any advantage gained in the enhanced likelihood of accuracy in litigation.²⁷

The utilitarian analysis is best illustrated by Dean Wigmore's four fundamental criteria:

- (1) The communications must originate in a confidence that they will not be disclosed.
- (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
- (3) The relation must be one which in the opinion of the community ought to be sedulously fostered.
- (4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.²⁸

Dean Wigmore argued that privilege recognition can only occur when all four conditions are met.²⁹ Specifically, he believed that people would continue seeking medical help and not refrain from disclosing confidential information whether or not any privilege existed.³⁰ Additionally, Dean Wigmore asserted that the injury to accurate litigation would be decidedly greater than any injury to the physician-patient relationship.³¹ He concluded that the doctor-patient privilege failed to satisfy either the second or fourth criteria, but never determined if the psychotherapist-patient privilege met each of the four criteria.³²

The utilitarian analysis is not without its critics.

Commentators have argued that it presents a highly conjectural analysis and defies scientific validation.³³ Lack of empirical evidence to support or discredit a privilege under this theory results in speculation and inaccurate conclusions.³⁴ Even when empirical data exists, the results often fail to support the costs or benefits claimed by privilege opponents/proponents.³⁵ Critics have also pointed to the absence of personal privacy considerations as a major failing in the utilitarian analysis.³⁶ Nonetheless, the utilitarian theory remains a valuable starting point in any privilege analysis.³⁷

2. The Privacy Analysis

The second basic theory is the privacy rationale.³⁸ Privileges are recognized under this theory, not because they satisfied a utilitarian systematic analysis, but because some underlying values involving the individual are more important than increasing the likelihood of an accurate resolution.³⁹ In other words, the privilege analysis shifts the focus to the individual instead of a balancing examination. Under this rationale, the privilege's primary purpose is to protect an individual from intrusions into certain human relationships. Exclusion of evidence in litigation is simply an incidental consequence of protecting the individual's right to be left alone.⁴⁰ The privileges protect interests and relationships, whether right or wrong, because they are of sufficient social importance to justify denial of information to factfinders.⁴¹

Most commentators advancing the privacy theory find the utilitarian analysis inadequate for some privileges but they do not ignore its value altogether. The utilitarian analysis "sheds light upon, and indeed wholly justifies, many privileges-especially those which have grown up around professional relationships."⁴² Professor Saltzburg proposed a hybrid analysis that evaluated the nonlitigation (quasi-privacy) values first and the litigation (quasi-utilitarian) values last.⁴³ Another writer proposed encompassing the privacy rationale within a full utilitarian framework, finding both compatible.⁴⁴ These two combinations still return to the original question, which rationale will remain preeminent. Will privacy values overcome society's desire to obtain more information? The method of structuring the analysis would in all likelihood determine the outcome.⁴⁵

The privacy theory is not without its problems either. Commentators argue that a privacy analysis must always be balanced against society's interest in the search for the truth.⁴⁶ It is extremely difficult, however, to objectively weigh the privacy interests involved, further complicating any comparison with the costs of denying access to information.⁴⁷ Opponents to privacy-based privileges cannot rely on the standard empirical analysis used in utilitarian circles. Instead, they must also

demonstrate disagreement by society on what privacy interests are considered worthy of protection against disclosure.⁴⁸

3. The Power Analysis

Consideration should be given to the power theory, when explaining how privileges have been traditionally justified. It is actually not an academic analysis of why a privilege should exist. Indeed, the power theory asserts that attempting to justify privileges is a waste of time.⁴⁹ It is a political perspective on why privileges exist at all. According to the theory, privileges originate from the political influence of those who benefit from them.⁵⁰ The power theory has been mentioned by various scholars as one explanation for the existence of privileges.⁵¹ Another indicator of this theory's potential influence can be found in the numerous recently passed state privilege statutes. The power structure of contemporary society is reflected in these statutes.⁵² This prompted one scholar to say "the poor man's only privilege is perjury."⁵³ The power theory offers little in the way of privilege analysis, so it will be left at this juncture for some future privilege adventurer.

B. PHYSICIAN VERSUS PSYCHOTHERAPIST

Critical distinctions exists between the general physician-patient privilege, and the psychotherapist-patient privilege. The unusually close relationship of trust and confidence required in psychotherapy demands special considerations unlike those given to ordinary doctor-patient relations.⁵⁴ The psychotherapeutic relationship is, by its nature, much more intimate and personal. "Mental ill-health is still a matter of which patients are likely to be more ashamed than physical ill-health or injury."⁵⁵ Psychotherapy is useless unless the patient feels assured from the beginning that whatever he says will forever remain confidential.⁵⁶ The need for confidentiality is important, not only within the therapeutic

relationship, but equally so for inducing a patient to begin therapy.⁵⁷ Patients experiencing physical injury, on the other hand, will normally seek medical treatment regardless of the risk of disclosure. There is little chance of stigmatization in being treated by a general practitioner for a physical injury.⁵⁸ The same cannot be said for treatment by a psychotherapist.

It is clear that the psychotherapist-patient situation is distinct in many ways from the physician-patient situation. Indeed, several commentators have analogized the psychotherapist-patient relationship to the priest-penitent relationship.⁵⁹ "While psychiatry and religion do not share the same orientation or basic assumptions, many of their basic concerns are the same."⁶⁰ Communications to clergy in the military are privileged if made either as a formal act of religion or as a matter of conscience.⁶¹ Statements made to psychotherapists may also stem from a matter of conscience as well as a desire to be treated for some perceived mental disorder.

C. UTILITARIAN ANALYSIS APPLIED TO PSYCHOTHERAPY

The psychotherapist-patient privilege presents a much stronger case for acceptance under the utilitarian theory than does the physician-patient privilege. The analysis begins by asking whether a testimonial privilege against disclosure is necessary to encourage communications between psychotherapists and their patients. Applying Wigmore's four postulates to this relationship will aid in the analysis.⁶²

First, confidentiality must be considered the cornerstone to a psychotherapist-patient relationship. Unlike the physician who may be able to cure ailments without the patient's trust or communications, the psychotherapist must have the patient's confidence.⁶³ In few other situations will an individual bare his soul and subject himself to the mental dissection of another.⁶⁴ Communications in the psychotherapist-patient relationship can only originate in confidence that they will not be disclosed.

Second, continued confidentiality is inherent to a complete and successful psychotherapist-patient relationship. Successful treatment usually requires patients to disclose matters that are personal and embarrassing.⁶⁵ The therapist has a unique relationship which allows access into the most intimate areas of the mind normally inaccessible to others.⁶⁶ The therapeutic relationship must develop over time, building upon past sessions, which allows the patient to establish a bond of security and trust in the therapist.⁶⁷ If patients suspect disclosure of their inner thoughts, they may lose all trust in their therapists or even sever the relationship.⁶⁸

Third, the psychotherapist-patient relationship is beneficial to society. These types of services are now being used more often than ever.⁶⁹ If patients knew that their feelings and statements made to therapists could be disclosed in the future, they may delay or avoid altogether seeking necessary treatment for a mental illness.⁷⁰ This harms society in two ways: (1) a mentally ill person who poses a possible danger to society is not treated either as soon as possible or at all, and (2) a mentally ill person is left with less capacity for productivity in society than a mentally fit person.⁷¹ The psychotherapeutic relationship is, therefore, one which should be fostered.

Finally, Wigmore's fourth criterion provides the strongest argument for recognition of the psychotherapist-patient privilege. Disclosure of confidences made in the relationship may not necessarily enhance the accurate disposal of litigation, but harm to the relationship by such action would substantially outweigh any potential benefit. To begin with, statements made in these relations may be fraught with fantasy, imagination and other unreliable information, of extreme importance to the psychotherapists but potentially dangerous in the courtroom.⁷² Litigation accuracy could just as likely be impaired as aided by this additional information. Introduction of unreliable evidence may complicate an already difficult fact-finding process. In addition, the damage to the psychotherapeutic relationship by court ordered disclosure of personal and potentially damaging

information exacerbates the mental health of an already ill person.⁷³ The ultimate result from compelling a therapist to testify in court has been double-edged. Patients divulge less critical information to their therapist, thereby decreasing the effectiveness of treatment. Additionally, therapists possess less information that is considered beneficial to the accuracy of litigation by fact-finders.⁷⁴ Society is in the original position it occupied before compelling psychotherapists to reveal confidential information. Litigation is just as (in)accurate as before, only now treatment of the mentally ill is adversely affected. Mentally ill people are treated less effectively or not at all.

D. PRIVACY ANALYSIS APPLIED TO PSYCHOTHERAPY

The psychotherapist-patient privilege, in addition to benefitting society under the traditional utilitarian analysis, is necessary to protect the privacy of the patient. It does not matter, under the privacy theory, whether patients will delay or avoid treatment for mental illness. What is important is that the individual's privacy, his innermost thoughts revealed to his psychotherapist in confidence, remain free from intrusion.⁷⁵ The exclusion of evidence at trial is only an incidental effect.

The term 'privacy' evokes images of a ubiquitous cloud that envelopes each individual, shielding what is within from the senses of others. We bring into this 'cloud' only those to whom we are willing to expose certain personal matters too. Few people disagree that we each have certain expectations of privacy that should be protected from the intrusions of others. Disagreement, of course, arises over how large a privacy 'cloud' society will accept. The privacy theory asserts that confidences revealed in the course of a psychotherapeutic relationship fall within this 'cloud' and should be privileged under common law.⁷⁶

Beginning in the 1960's, the United States Supreme Court began to identify and define a constitutional right of privacy, which protects individuals from invasion of some of the most intimate aspects of their lives.⁷⁷ These constitutional protections

have expanded in several ways. The Court has recognized privacy interests in: Avoiding disclosure of personal information;⁷⁸ the individual's right to make decisions without government interference;⁷⁹ the individual's right to keep communications confidential;⁸⁰ maintaining the sanctity of the individual's body;⁸¹ and certain places in which the individual is located.⁸² The "right to be let alone" has been characterized as the most valued right of civilized men.⁸³

In the substantial number of Supreme Court decisions in the past twenty years invoking a constitutional right of privacy, no case has established or denied such a right with respect to patient disclosures to psychotherapists. Some state courts, however, have recognized that the psychotherapist-patient privilege is protected from intrusions by the United States Constitution.⁸⁴ These federal and state decisions imply that privacy may be a constitutionally mandated protection of confidential communications in the psychotherapeutic relationship or, at the least, an expanding concept that should weigh heavily in balancing the various interests of any privilege analysis. The psychotherapist-patient privilege, therefore, finds strong support in the privacy protections emanating from the Bill of Rights in the Constitution.⁸⁵

III. PSYCHOTHERAPIST-PATIENT PRIVILEGE: ALIVE AND GROWING

Psychotherapeutic relationships have received increasing recognition as a unique area distinct from general physician-patient relationships. This attention has manifested itself in various ways. Congress gave serious consideration to a proposed psychotherapist-patient privilege when promulgating the Federal Rules of Evidence, before finally selecting a generalized rule of privilege.⁸⁶ Federal courts wrestled with the psychotherapist-patient privilege when attempting to identify and define its existence in light of federal common law and Federal Rule of Evidence 501.⁸⁷ Even some federal statutes have the effect of according rights similar to a psychotherapist-patient

privilege in certain situations,⁸⁸ although arguments for a court-created psychotherapist-patient privilege are lessened to some degree by the statutes.⁸⁹ The states have been the most ardent supporters of the psychotherapist-patient privilege. Many adopted state evidence code sections similar to the proposed federal psychotherapist-patient privilege rule.⁹⁰ The current trend in courts and legislatures is towards recognizing the distinctions between psychotherapists and physicians, either by statute or case law.

A. DEVELOPMENT OF PRIVILEGES IN THE FEDERAL RULES OF EVIDENCE

Beginning in 1961, the Supreme Court, Congress, noted scholars, and other interested parties spent more than 13 years developing the current Federal Rules of Evidence.⁹¹ In March, 1969, a preliminary draft of the proposed rules of evidence was prepared by an advisory committee and circulated widely for comment.⁹² Article V of the draft purported to enumerate all privileges to be recognized in the federal courts. Any unlisted privilege was considered nonexistent and of no effect unless of constitutional dimension.⁹³ The article contained 13 rules, 9 of which defined specific nonconstitutional privileges, including a psychotherapist-patient privilege.⁹⁴ The proposed rules underwent two subsequent revisions in 1971 and 1972 before the Supreme Court transmitted them to Congress in 1973.⁹⁵

It became immediately clear to Congress that the privilege provisions were extremely controversial.⁹⁶ Disagreement over the privilege rules threatened to prevent passage of the remaining sections.⁹⁷ Ultimately, the privilege section was eliminated and a single rule was substituted in its place.⁹⁸ When the Federal Rules of Evidence became public law, privileges would henceforth 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."⁹⁹ This ostensibly sounded a death knell to the proposed psychotherapist-patient privilege, except for the

comments on the rules in the accompanying Senate Report, subsequent federal case law, and state legislation.¹⁰⁰ Their combined effect, which will be discussed later, gave new life to the psychotherapist-patient privilege.

1. PROPOSED FEDERAL RULE OF EVIDENCE 504

Proposed Rule 504 did not contain a general physician-patient privilege.¹⁰¹ The drafters recognized the distinction from psychotherapy, citing the report of the Group for the Advancement of Psychiatry, which provided:

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....

(T)here 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.¹⁰²

The 1971 draft of the rule expanded the definition of psychotherapists to include general physicians when performing psychotherapist-type treatment.¹⁰³ This was designed to allow general practitioners who treat psychosomatic conditions part of the time. Expanding the definition, but not requiring physicians to practice psychotherapy more than part of the time, created a quasi-physician-patient privilege, contrary to the original intent of the drafters of Proposed Rule 504.¹⁰⁴

Unlike physicians under the proposed rule, psychologists had to be licensed or certified.¹⁰⁵ This removed from protection

the wide number of lay persons claiming to provide psychotherapeutic services.¹⁰⁶ Sections (b) and (c) of the rule defined confidential communications and the general rule of privilege in terms not unlike other rules of privilege.¹⁰⁷ The final interesting characteristics of the Proposed Rule 504 were the three exceptions to the general rule of privilege: Proceedings for hospitalization of the patient, testimony based on court ordered examinations of the patient's mental or emotional condition, and cases in which the patient's mental or emotional condition are in issue.¹⁰⁸ The first two exceptions would be inappropriate for military court-martial proceedings for two reasons. First, courts-martial only have jurisdiction to try criminal cases, not to conduct hearings for involuntary hospitalization. Second, other military evidence rules address disclosure of statements made at compelled mental examinations.¹⁰⁹ Additionally, the unique nature of the military system may require additional exceptions before it could be acceptable.

The adoption of the Federal Rules of Evidence created an important issue regarding the role of the proposed-but-rejected psychotherapist-patient privilege in determining whether such a privilege exists under federal common law. The rule represented years of effort by distinguished and capable men and is therefore entitled to a certain degree of respect.¹¹⁰ Conversely, opponents to the privilege argued that rejection by Congress of the specific rule was equally significant.¹¹¹ Indeed, there was some evidence that the proposed rule was considered unsatisfactory to physicians and patients alike, which contributed to the dilemma Congress faced prior to the rule's demise.¹¹² But a close review of the Senate Report on deletion of the psychotherapist-patient privilege lessens to some extent this argument.

Congress simply avoided controversy and selected the easier route by deleting the privilege section, expediting passage of the remaining rules. Their actions were indicative of impatience rather than opposition to the rule. This impatience was due in large part to the strong lobbying effort of medical groups to be included within the proposed rule.¹¹³

Proposed Rule 504 was not criticized because psychotherapist were granted a privilege. On the contrary, it was attacked because it was not broad enough. Speaking before the House Subcommittee on Criminal Justice, one spokesperson representing the American Orthopsychiatric Association, the American Psychological Association, and the National Association of Mental Health argued that the rule was too restrictive; it gave no protection to physicians or unlicensed psychotherapists.¹¹⁴ This was contrary to the laws of two-thirds of the states at that time.¹¹⁵ She argued that the federal law of privileges should be left to the states rather than risk losing what privileges currently existed in the federal courts.¹¹⁶ A member of the Subcommittee, Representative Dennis of Indiana, went so far as to admit to Congress that the privileges were matters of substantive law rather than simply rules of evidence, and that they should be left to the states to decide instead of codification in the rules of evidence.¹¹⁷ This is certainly a different reason than offered in the Senate for replacing the rules, namely to avoid a stalemate in the passage of the entire package.¹¹⁸ The clear thrust of these comments and those of other witnesses to the hearings was a fear that the proposed rule would preclude application in federal courts all state physician-patient privileges already in place.¹¹⁹ The medical community wanted a broader rule or no rule at all, thus accepting nothing less than what they already possessed.

Ignored in the debate, but of particular importance to this thesis, was the bifurcated nature in which the privilege rules were applied. The Proposed Rule 504 was written to provide uniform application in both civil and criminal federal trials. State rules of privilege would normally be of concern only in federal civil cases involving federal questions or diversity jurisdiction.¹²⁰ They would have no direct impact on rules of evidence in federal criminal trials since only federal law would apply. The medical community had no explicit privilege protection in those forums to begin with. Congress may have satisfied the medical community by rejecting Proposed Rule 504, but it simultaneously removed the only explicit psychotherapist-patient privilege provided for federal

criminal courts. This perspective should lessen to some extent arguments that the proposed-but-rejected rule is of little significance today in analyzing psychotherapist-patient privileges under the common law in Federal criminal trials.

Proposed Rule 504 is a valuable starting point in a federal common law analysis for another important reason. Following the rule's demise, Congress received substantial correspondence from psychiatric organizations and psychiatrists.¹²¹ The psychiatric profession was concerned that Congress was removing any possible psychotherapist-patient privilege in the Federal Courts. Clarification by Congress was immediate and to the point. The Senate Report accompanying the Federal Rules of Evidence stated:

[I]n approving this general rule as to privileges, the action of Congress should not be understood as disapproving any recognition of a [psychotherapist-patient privilege] ... or any other of the enumerated privileges contained in the Supreme Court rules....

(T)he recognition of a privilege based on a confidential relationship and other privileges should be determined on a case by case basis.¹²²

Proposed Rule 504 is, therefore, a worthwhile source of information in shedding light on any federal common law psychotherapist- patient privilege analysis.

2. FEDERAL RULE OF EVIDENCE 501

The general privilege embodied in Federal Rule of Evidence 501 could be accurately characterized as Congressional side-stepping.¹²³ It was drafted by the House Subcommittee to replace the original 13 privilege rules transmitted to Congress by the Supreme Court.¹²⁴ The Senate Report accompanying FRE 501 stated that it was created because disagreement over the proposed privilege rules threatened passage of the the remaining rules.¹²⁵ In addition, lobbying efforts of various interest groups contributed to the dissension.¹²⁶ The new rule returned privilege law to its previous status.¹²⁷ Congress wanted the

federal courts to continue the evolution of testimonial privileges in federal criminal trials. They were to be governed by the principles of the common law as they may be interpreted in the "light of reason and experience."¹²⁸ Congress did not intend to freeze the law of privilege by rejecting the proposed rules and enacting FRE 501. Instead, its purpose was to insert flexibility in the courts to allow development of the rules of privilege.¹²⁹

Traditionally, federal courts have decided issues of privilege in criminal trials in accordance with the guidance of FRE 501.¹³⁰ This means that those privileges recognized prior to the development of the Federal Rules of Evidence were still valid. In addition, the courts were encouraged to continue the development of privileges on a case-by-case basis.¹³¹ The actual effect has been to slow, but not stop, development of the psychotherapist-patient privilege.

FRE 501 prescribes a general privilege for any "witness, person, government, State, or political subdivision..." in federal criminal proceedings.¹³² In federal civil actions involving "an element of a claim or defense as to which State law supplies the rule of decision," state privilege would apply unless some overriding federal interest existed.¹³³ When federal criminal courts enforce federal law, FRE 501 requires application of federal privilege law instead.¹³⁴ This thesis will only discuss FRE 501's application to criminal cases, consistent with the criminal jurisdiction of military courts.

3. FEDERAL CASE LAW

The psychotherapist-patient privilege has received mixed reviews in the federal courts. Some try to avoid the issue and rule on other grounds.¹³⁵ Courts that fail to recognize a psychotherapist-patient privilege normally do not distinguish psychotherapists from physicians.¹³⁶ Their analysis would concern whether a physician-patient privilege existed. Since there was no physician-patient privilege at common law, they saw little reason to recognize one, even for psychotherapists.¹³⁷

These decisions in general add little to any privilege analysis because they fail to search beneath the surface and discuss the principles involved in psychotherapy.

Today, many courts recognize that the psychotherapist-patient relationship is a unique discipline worthy of more deliberation than the general physician-patient relationship.¹³⁸ These courts analyzed its complexities, cognizant of the principles involved. These decisions have primarily discussed the issue in terms of privilege or privacy rights,¹³⁹ similar to the utilitarian and privacy theories espoused earlier.¹⁴⁰ Additionally, when Proposed Rule 504 was considered by Congress and ultimately replaced with FRE 501, many courts gave greater attention to the proposed-but-rejected rule.¹⁴¹

In order to resolve whether a psychotherapist-patient privilege should exist in the military justice system, it is necessary to determine how the better reasoned federal court decisions have treated the issue. The cases have varied among Proposed Rule 504, Wigmore's utilitarian theory, and privacy arguments in their analysis, usually in some combination of the three.

a. In Re Zuniga

The most significant federal case concerning the psychotherapist-patient privilege is In Re Zuniga.¹⁴² This was the first federal appeals court to bestow common law status to the privilege.¹⁴³ In the decision, two psychotherapists were held in civil contempt for failing to respond to a subpoenas duces tecum issued by two separate grand juries.¹⁴⁴ The records were sought in relation to investigations of alleged fraud in Blue Cross-Blue Shield billings.¹⁴⁵ The 6th Circuit affirmed the contempt judgements, holding that patient identity, treatment dates, and length of treatment was not information protected by the psychotherapist-patient privilege, nor did it unconstitutionally infringe on privacy rights.¹⁴⁶ The decision is most important for

its analysis and recognition of the privilege, despite not enforcing the privilege in the case.

The Sixth Circuit relied on the legislative history of Proposed Rule 504 to a great extent in creating a basis in federal common law to recognize the psychotherapist-patient privilege.¹⁴⁷ They were not impeded in their analysis by Congressional rejection of Proposed Rule 504. Instead, they viewed the new generalized rule, FRE 501, as a mandate to continue developing testimonial privileges in federal criminal trials "governed by the principles of the common law as they may be interpreted... in the light of reason and experience."¹⁴⁸ This provided greater flexibility to the courts to develop rules of privilege on a case by case basis.¹⁴⁹

The Zuniga court also pointed to the position of the states as another factor in its analysis.¹⁵⁰ Almost every state has shown a willingness to recognize some form of physician-patient, psychologist-patient, or psychotherapist-patient privilege.¹⁵¹ In federal criminal trials, federal law controls, but the Supreme Court has indicated "that the privilege law as developed in the states is [not] irrelevant," and "has taken note of state privilege laws in determining whether to retain them in the federal system."¹⁵² If almost every state recognizes some form of psychotherapist-patient privilege, federal common law analysis cannot ignore this direct reflection of the importance society places in the relationship. Military law, despite readiness concerns unique to its mission, must give similar credence to this trend.

Another part of the Zuniga opinion offered a noteworthy utilitarian analysis. As discussed earlier, Wigmore's four privilege criterion provided the traditional utilitarian framework.¹⁵³ The Zuniga panel never explicitly addressed Wigmore's conditions. Yet, in a two step analysis, they accomplished just that.

First, the court determined whether a privilege should be recognized under the federal common law, addressing Wigmore's second, third, and fourth conditions.¹⁵⁴ The court acknowledged

the need for confidentiality in the psychotherapist-patient relationship, citing the comment of the Advisory Committee Notes which stated, "confidentiality is the sine qua non for successful treatment."¹⁵⁵ Society's interest in fostering the relationship was twofold; it allowed for successful treatment of mentally ill persons to reduce the threat to the community, and it enabled individuals to actively enjoy life and exercise many fundamental freedoms.¹⁵⁶ Considering the states' positions, legislative history of the privilege rules, and the comments of many scholars, the court found that "these interests... outweigh the need for evidence in the administration of criminal justice."¹⁵⁷ Having implicitly answered Wigmore's last three conditions affirmatively, the court concluded that a psychotherapist-patient privilege was mandated by "reason and experience."¹⁵⁸

The Zuniga court then undertook the second step in its analysis to determine the scope of the newly recognized privilege. Again, implicitly, the court conducted a utilitarian analysis using Wigmore's first and fourth conditions.¹⁵⁹ The information sought in the subpoena included patient identity, facts and time of treatment.¹⁶⁰ This information did not constitute the type of communication a patient would expect to remain confidential since it had already been revealed to a third party, Blue Cross-Blue Shield.¹⁶¹ Wigmore's fourth condition then served as the panel's basis for its decision. In weighing all relevant competing interests, the court determined that disclosure of the information was not harmful to the psychotherapeutic relationship since it did not violate any assurance to the patients that their innermost thoughts would remain confidential.¹⁶² The Zuniga opinion demonstrated that the utilitarian analysis is still a valid tool in any privilege analysis.¹⁶³

Zuniga raised an alternative issue concerning whether a constitutional right of privacy attaches to the psychotherapist-patient relationship.¹⁶⁴ The court used a balancing test drawn from the Supreme Court's decision in Whalen v. Roe to hold that enforcement of the subpoenas did not unconstitutionally infringe on the patients' rights.¹⁶⁵

Specifically, the intrusion into the patient's privacy interest was outweighed by the need for the grand jury to conduct its investigation.¹⁶⁶ The court left open for further speculation the way in which the scales would tip should the information be used as evidence in a criminal trial.¹⁶⁷ Indeed, the privacy argument would be much stronger against disclosure if the privileged information were offered in open court. Such a distinction might exist in the military justice system if similar information were sought for an Article 32 hearing versus a court-martial, although Article 32 hearings do not retain the veil of secrecy attending grand jury proceedings.

Zuniga provides a modern example of the correct psychotherapist-patient privilege analysis to be conducted. It reflects a detailed review of the most important factors to be considered. Unfortunately, few other cases have conducted as detailed an analysis.

b. OTHER FEDERAL CASES

(1). PROPOSED RULE 504

Proposed Rule 504, and its legislative history appeared in several other federal cases analyzing the psychotherapist-patient privilege. In United States v. Meagher, the Fifth Circuit declined to recognize a physician-patient privilege concerning incriminating letters a defendant sent to his psychiatrist.¹⁶⁸ The court, unfortunately, made no distinction between physicians and psychotherapists.¹⁶⁹ It did, however, find that if Proposed Rule 504 had been adopted by Congress, the letters would have been expressly excepted from the privilege when the defendant raised an insanity defense.¹⁷⁰ The Fifth Circuit only refused to recognize the physician-patient privilege. It remains to be seen whether different facts will prompt that Circuit to summarily dismiss the privilege again. The panel evidently recognized that the history of Proposed Rule 504 contributed to the common law analysis of privileges. Indeed, why would the panel discuss

Proposed Rule 504 at all unless its history has some bearing on the common law analysis of privileges?

The most accurate statement concerning Proposed Rule 504's status in federal court privilege analysis is that "it still provides a useful standard from which analysis can proceed."¹⁷¹ The rule provides strong guidance necessary to formulate the new privilege, using FRE 501 as the authority for federal court recognition.¹⁷² One must simultaneously recognize that evidentiary privileges are not to be created lightly nor expansively construed because they inhibit the search for the truth.¹⁷³

(2). UTILITARIAN ANALYSIS

Other federal courts have also found the utilitarian theory useful in their analysis. In a second circuit opinion, In Re Doe, the panel refused to prevent disclosure of psychotherapist-patient files where the relationships failed to satisfy Wigmore's four requirements.¹⁷⁴ Specifically, the court focused on the fourth condition and determined, based on an in camera inspection by the trial court, that there were no communications in the files of the intensely personal nature that were designed to be protected by the psychotherapist-patient privilege.¹⁷⁵ In another case, United States v. Friedman, the defendant in a criminal trial subpoenaed psychiatric records of anticipated witnesses against him.¹⁷⁶ The district court concluded that the material sought was "the type of intensely personal communications that the psychotherapist-patient privilege (was) designed to protect."¹⁷⁷ Contrary to the In Re Doe case, the court found all four of Wigmore's conditions satisfied, holding that the records were protected by the psychotherapeutic privilege.¹⁷⁸

(3). PRIVACY ANALYSIS

The Supreme Court has recognized that "a right of personal privacy, or a guarantee of certain areas or zones of privacy,

does exist under the Constitution."¹⁷⁹ This protection has been described involving two different kinds of interest; the individual interest in preventing disclosure of personal matters, and the individual interest in making important decisions free from government intrusion.¹⁸⁰ Although, still largely undefined, the right of privacy could include the doctor-patient relationship. In Roe v. Wade, the court implicitly included the doctor-patient relationship within the 'zone' when it first recognized the right of privacy in a woman's decision "whether or not to terminate her pregnancy."¹⁸¹

The Court was more explicit in Doe v. Bolton, bringing the doctor-patient relationship within the sphere of privacy when it struck down a Georgia statute that attempted to unduly restrict a physician's judgement in dealing with patients regarding the abortion decision.¹⁸² "The woman's right to receive medical care in accordance with her licensed physician's best judgement and the physician's right to administer it are substantially limited by this [statute]."¹⁸³ The Court recognized that a right of privacy protects intimate relationships when certain topics are involved. The logic in extending the right of privacy to the doctor-patient relationship when intimate topics are discussed is consistent with, though not mandated by Supreme Court case law. In Paris Adult Theatre I v. Slaton, the Court stated, "the constitutionally protected privacy of family, marriage, motherhood, procreation and child rearing is not just concerned with a particular place, but with a protected intimate relationship. Such protected privacy extends to the doctor's office...."¹⁸⁴

This implicit constitutional right of privacy includes both the individual's right to prevent disclosure of confidential communications in the relationship, and the individual's right to make decisions concerning psychiatric care without government interference.¹⁸⁵ The Supreme Court decisions concerning privacy focused primarily on home and family, however, it would be too restrictive a reading of precedent to not include personal communications made pursuant to the physician-patient relationship.¹⁸⁶ Arguments asserting a constitutional right of

privacy in the physician-patient relationship are more persuasive where the relationship is between the psychotherapist and his patient.¹⁸⁷ The particularized need for trust and confidentiality are deeply rooted in the relationship. Psychotherapists engage in communications with patients that are likely to be intimate and extremely personal.¹⁸⁸ The psychotherapist-patient relationship should, therefore, be included within the constitutionally protected right of privacy.¹⁸⁹

This privacy right is not, however, an absolute protection.¹⁹⁰ The analysis still focuses on the individual, although certain interests may become "sufficiently compelling," causing constitutional protections to yield.¹⁹¹ These encroachments must still be narrowly drawn to reflect only those compelling interests that justify intrusion into constitutionally protected relationships.¹⁹² In the abortion decision, government interests did not become "compelling" until the fetus was capable of meaningful life outside the mother's womb.¹⁹³

Lower courts have paid close attention to the "compelling" standard in assessing challenges to the psychotherapist-patient privilege. In United States v. Lindstrom, the panel recognized the privacy interest in communications and medical records flowing from a psychotherapeutic relationship.¹⁹⁴ Nonetheless, the court waived the privilege in the face of another compelling constitutional protection, the right of a defendant to cross-examine effectively a witness in a criminal case.¹⁹⁵ In another case, a broadly drafted state statute allowing issuance of warrants to search offices and records of medicaid providers was struck down because the statute as drafted was unnecessary to support the "compelling" state interest, to insure services and supplies that were billed were actually provided.¹⁹⁶

In a related case, the Third Circuit extended the right of privacy to employee's medical records.¹⁹⁷ The government sought access to the records pursuant to the Occupational Safety and Health Act to facilitate research and investigations.¹⁹⁸ The court made note of the intimate and personal facts normally contained within medical records in distinguishing the case from the

authorized government intrusion of Whalen v. Roe.¹⁹⁹ In Whalen, the Supreme Court upheld a New York statute requiring physicians to provide a form identifying patients and other personal information every time a dangerous legitimate drug (Schedule II) was prescribed.²⁰⁰ Recognizing the special character of this type of information, the court, nonetheless, conceded that the privacy protection must yield upon a showing of a proper (compelling) governmental interest.²⁰¹ Such compelling government interests could include reporting requirements relating to "venereal disease, child abuse, injuries caused by deadly weapons, and certification of fetal death."²⁰²

In Westinghouse, the court identified several factors to consider in determining whether an intrusion into an individual's privacy is justified. These included:

the type of (information) requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate articulated public policy, or other recognizable public interest militating toward access.²⁰³

The court eventually granted access because the government interest in investigation outweighed the individual privacy interest.²⁰⁴

The value placed on the individual's right to prevent disclosure of personal information manifested in these decisions suggests an additional firm policy basis for the psychotherapist-patient privilege. Certainly, the more personal and intimate nature of the psychotherapeutic relationship earns greater deference and consideration when balanced against competing governmental interests at stake. Even in the military justice arena, individual privacy interests are legally relevant and should be accorded significant weight in any analysis concerning establishment or recognition of a psychotherapist-patient privilege.

The federal court cases demonstrated some reluctance to recognize a psychotherapist-patient privilege under FRE 501, and even more reluctance to use it as a shield to prevent disclosure. They have, however, uniformly demonstrated recognition that the unique nature of the psychotherapeutic relationship merits closer scrutiny. No longer can courts risk ignoring the distinctions from the general physician-patient relationship. The legislative history to Proposed Rule 504, growing acceptance of the mental health profession, state action in this privilege area, and constitutional privacy arguments all serve to signal the federal courts that summary dispositions of privilege arguments will no longer suffice. Every court will, ultimately, have to deal with psychotherapeutic issues and demonstrate better reasoning before dismissing the psychotherapist-patient privilege's application.

Similar concerns must be addressed in military courts. In Military Rule of Evidence 501(a)(4), military courts are explicitly directed to consider common law principles applied in federal courts pursuant to FRE 501 "insofar as the application of such principles in trial by courts-martial is practicable and not contrary to or inconsistent with the code, (the) rules, or (the) Manual."²⁰⁵ It may appear that the language restricts the creation of new privileges, but it does not prevent their recognition altogether. Indeed, one commentator has noted that the constant development of privilege law in federal courts will most likely result in similar changes in military privilege law.²⁰⁶

4. INDIRECT FEDERAL STATUTORY RECOGNITION

Several federal statutes protect the confidentiality of patients and their medical records when being treated for mental illness or drug dependency.²⁰⁷ Their enactment may lessen the need for federal courts to create privileges in those areas. That argument reflects only a superficial reading of their provisions, however. Their passage attests to the perceived need for confidentiality of personal medical information. The lawmakers apparently felt that

the potential harm from public disclosure of this information merited additional safeguards in the laws.

For example, the Surgeon General may authorize persons engaged in research for mental health, including research on the use and effect of alcohol and psychoactive drugs, to withhold from anybody not connected to the research information concerning the identity or other characteristics of subjects in the research.²⁰⁸ Such persons cannot be compelled to provide that information in any "Federal, State, or local civil, criminal, administrative, legislative, or other proceeding."²⁰⁹

Another statute ensures the confidentiality of medical records, diagnosis, prognosis and treatment of any person enrolled in a drug abuse prevention program conducted, regulated or in any way assisted by any agency or department of the government.²¹⁰ It is interesting to note that this statute did not apply to interchange of records within the armed forces, although certain Army Regulations have the same effect.²¹¹ Congress provided additional guarantees of confidentiality for mentally ill persons in Public Law 99-319.²¹² The Act included a section detailing a "Bill of Rights" for anyone receiving mental health services in any program or facility.²¹³ Such persons are to be guaranteed confidentiality of their mental health care records pursuant to that treatment.²¹⁴ The confidentiality remains in force even after the patient's discharge from a program or facility.²¹⁵

These statutes do not explicitly create a psychotherapist-patient privilege, nonetheless, that is how they are perceived.²¹⁶ They also represent a concern of the legislature to protect people undergoing drug rehabilitation or mental health care. There are two dangers inherent in the programs absent any guarantees of confidentiality. Individuals undergoing the treatment could suffer embarrassment, stigma or other harm from public disclosure of their participation. Additionally, the effectiveness and ultimate success of the programs would be threatened if people did not use the services for fear of disclosure. Society wants to punish wrongdoers who

use drugs or engage in other criminal activities due to some psychosis. Society also benefits from rehabilitating the drug user and treating the mentally ill individual. These statutes represent one way in which Congress has sought to tip the scales away from punishment, towards more treatment and rehabilitation. This is particularly necessary in the absence of codified rules of evidence protecting these types of relationships. The states, on the other hand, have been much more direct in addressing these problems.

B. STATE PSYCHOTHERAPIST-PATIENT PRIVILEGE LAWS

The states have been much quicker to respond to the problems of confidentiality in medical health relationships. Beginning with New York in 1828, the first of many privilege statutes for physician-patient relationships was created.²¹⁷ The absence of a physician patient privilege at common law did not deter this movement. Today, a total of forty states plus the District of Columbia have statutes or rules of evidence recognizing a general privilege in physician-patient relationships.²¹⁸ The trend is even more dramatic in the field of psychotherapy. Currently, forty-eight states and the District of Columbia have statutes or rules of evidence recognizing a psychiatrist-patient, psychologist-patient, or psychotherapist-patient privilege.²¹⁹

The statutes and evidentiary rules differ widely in their formulation of the privileges, which often include many exceptions.²²⁰ A common thread among most state schemes, however, is a preference to give psychotherapists more protection than physicians against disclosure. For example, some states grant physicians a privilege in civil trials while giving psychotherapists both civil and criminal trial privilege.²²¹ Additionally, many states include provisions which equate the psychotherapist-patient privilege with their attorney-client privilege.²²² Very few states, however, give similar protection to their physician-patient privilege.²²³ These trends demonstrate

that the states recognize two very important points: First, the psychotherapeutic relationship deserves greater protection from disclosure than the general physician-patient privilege; second, the psychotherapist-patient relationship needs trust and secrecy in communications, similar to that in the attorney-client relationship, in order to be effective in treating the patient.²²⁴

Another prevalent theme in the state provisions is the almost wholesale adoption of the psychotherapist-patient privilege contained in the proposed federal rules. Proposed Rule 504, deleted by Congress, was amended and placed into the 1974 Uniform Rules of Evidence as Rule 503.²²⁵ The amendment allowed states an option to include a physician-patient privilege in the original Proposed Rule 504.²²⁶ Most states duplicated major portions of that rule into their provisions.²²⁷

As previously stated, the proposed rule reflected substantial thought and efforts by renowned attorneys. It is, therefore, no surprise that the states relied on that work to such a great extent. State reliance on the proposed rule gives greater weight to arguments that the proposed rule should be an important factor in any psychotherapist-patient privilege analysis.

Exceptions to any privilege rule tend to neutralize its effectiveness. Every time a privilege rule is abrogated because of an overwhelming compelling interest, the relationship suffers. The state medical health privileges contain numerous exceptions, arguably lessening to some extent the perceived social value placed on the privilege. There was substantial agreement among the states with the drafters of Proposed Rule 504 that in three instances, the need for disclosure outweighed any possible impairment of the psychotherapist-patient relationship.²²⁸ These included proceedings for hospitalization of the patient, judge ordered examinations, and cases where the patient's medical condition was an element of his claim or defense.²²⁹

Noticeably absent from Proposed Rule 504 was an exception for instances of identified or suspected child abuse.²³⁰ It was probably not even considered as an exception at the time since public attention to child abuse was not as focused as it is today.

The states, on the other hand, have already dealt with this issue in their statutes and rules. Today, every state and the District of Columbia have laws requiring psychotherapists and physicians, among others, to report to the appropriate authorities any circumstance where they reasonably believe a child has been neglected or abused or is about to be neglected or abused in the near future.²³¹ All of these statutes supersede any protection afforded by the medical privilege statutes. Additionally, many states explicitly abrogate those privileges when child abuse is involved.²³² Societal concern for our children's welfare has become a compelling state interest that will overcome any utilitarian or privacy arguments for upholding a conflicting psychotherapist-patient privilege. If Congress or the military should consider and ultimately adopt a psychotherapeutic privilege, it would be essential to include as an exception any confidential communications relating to suspected or anticipated child abuse.

Child abuse is but one example of how the states do not let the psychotherapist-patient privilege shield information from the courtroom when a compelling interest is at stake. Another frequent waiver of the psychotherapist-patient privilege occurs when the therapist reasonably believes that the patient is a menace to himself or to others. Normally, the privilege is explicitly waived by statute or rule, but usually the psychotherapist is given an affirmative duty to report the threat to an appropriate authoritative agency.²³³ Many psychotherapists are especially sensitive to this requirement because of the risk of litigation when a patient follows through on his expressed impulse.²³⁴ Some states abrogate the psychotherapist-patient privilege when serious criminal misconduct is potentially involved, such as gunshot wounds²³⁵ and homicide.²³⁶ Other exceptions occur when the elderly²³⁷ or mentally incompetent are the victims of abuse.²³⁸ Finally, some states give the trial judge discretion to disallow the privilege in unique situations. For example, North Carolina and Virginia allow their trial courts to disallow valid

psychologist-patient and physician-patient privileges if disclosure is necessary to a proper administration of justice.²³⁹

The psychotherapist-patient type privileges have become substantive rules of evidence in most of the states. Their existence creates expectations in both patients and therapists in their relationships. It is very likely that many of them are unaware that those same privileges do not explicitly exist in federal criminal proceedings or courts-martial. Perhaps ignorance of this fact means that no chilling effect occurs in the psychotherapeutic relationships. That would lessen to some extent the utilitarian arguments in favor of the privilege. There would be, however, an egregious intrusion on the privacy of the relationship when disclosure is ultimately required where the parties relied on state privilege law in their therapy.

Several points can be drawn from the state by state treatment of the psychotherapist-patient relationship. First, as stated earlier, there is overwhelming support for the privilege in society today. All but two states have adopted one form or another of the psychotherapeutic privilege. Second, deletion of Proposed Rule 504 by Congress did not diminish its value as a starting point in any psychotherapist-patient privilege analysis. Indeed, many states relied on the proposed rule as a basic framework upon which to build their own rules. This fact underscores the need to avoid dismissing the proposed rule out of hand without first addressing it, a fact all too often forgotten in military courts-martial.²⁴⁰

Third, an absolute psychotherapist-patient privilege is impractical. The states recognize at least four situations where the privilege gives way to stronger countervailing interests every time.²⁴¹ The unique needs of a forum may also dictate further exceptions. For example, the military interest in protecting the nation may necessitate a provision allowing the military judge to waive the privilege if nondisclosure would be detrimental to the national security.²⁴² It must be remembered, however, that each exception to a privilege rule tends to frustrate the purpose of the rule.

Finally, the disparity of treatment in psychotherapeutic communications between state and federal forums allows inequitable situations to develop. Anytime an individual seeks treatment for a mental or emotional disorder, regardless of how innocuous his behavior, the potential for embarrassing disclosure is always present. If the patient is a witness or a defendant in a federal criminal trial, this intimate and personal information will be hanging over his head, subject to being admitted into evidence as long as it is relevant for the purpose for which it is offered. Any competent advocate can normally articulate a plausible basis to overcome that hurdle. Conversely, there is precious little that the opposing advocate can do to stop this intrusion unless he is in one of the forums that recognize the privilege under FRE 501. There must come a time when the relentless pursuit of all relevant information in a criminal trial has to give way in order to allow individuals an opportunity to receive the most beneficial and effective therapy possible. In the military, the dogged pursuit rarely yields.

IV. TREATMENT OF PSYCHOTHERAPY UNDER THE MILITARY RULES OF EVIDENCE

A. ANTIMEDICAL PRIVILEGE BIAS OF THE MILITARY

The military has always been explicit and intransigent in its nonrecognition of any physician-patient privilege. Every Manual for Courts-Martial contained a provision making this patently clear.²⁴³ Maintenance of the health and fitness of soldiers was considered paramount over such a privilege.²⁴⁴ Another factor in the military's opposition to a physician-patient privilege was undoubtedly the lack of a similar privilege at common law.²⁴⁵ Military Rule of Evidence 302 created an apparently limited medical privilege regarding compelled mental examinations of an accused, yet, the drafters stated very clearly that it was not a doctor-patient privilege.²⁴⁶ Furthermore, physician-patient privilege laws were also described as inapplicable in the military

forum.²⁴⁷ Instead, the real purpose of Rule 302 was to protect the accused's privilege against self-incrimination.²⁴⁸

There would be no chance of recognizing a privilege for psychotherapists if the Military Rules of Evidence were fixed in stone. Fortunately, military law is not so intractable to resist the forces of social change when they are compelling.

The fundamental basis upon which all rules of evidence must rest.... is their adaptation to the successful development of the truth....[A] rule of evidence at one time thought necessary to the ascertainment of truth should yield to the experience of a succeeding generation whenever that experience has clearly demonstrated the fallacy or unwisdom of the old rule."²⁴⁹

The doctor-patient privilege rejected in military law represents too broad a stroke. There is room to consider a narrower medical privilege for psychotherapists.²⁵⁰

1. BLURRING PSYCHOTHERAPIST-PATIENT DISTINCTIONS

The military has never analyzed the distinction between psychotherapists and physicians. Psychiatrists are medically licensed physicians by education and have uniformly been treated as general practitioners.²⁵¹ Psychologists, on the other hand, are normally not medically licensed. More likely, they possess a graduate degree in psychology, such as a Ph.D..²⁵² Military courts have sometimes considered psychologists lacking in the training and experience necessary to testify about an individual's mental or emotional condition.²⁵³ Psychologists have, however, recently achieved substantial recognition for their abilities. Previously, each medical board conducting a mental examination had to include at least one psychiatrist.²⁵⁴ Under the 1986 Amendment to the Manual, a mental evaluation board can now be conducted without a psychiatrist, using a clinical psychologist on the board instead.²⁵⁵ Clinical psychologists are, in essence, accorded equal status with psychiatrists when conducting mental examinations pursuant to R.C.M. 706.²⁵⁶ This is a significant

acknowledgement in military law of the status and ability of clinical psychologists. Because of the change, military psychologists can be expected to testify more frequently on the issue of mental competency.²⁵⁷

2. COMMON SCENARIOS

Psychotherapist-patient communications have usually been offered into evidence in three instances: First, when the accused has undergone a compelled mental examination for the government;²⁵⁸ second, when the accused has his own psychotherapist on the issue of mental competency;²⁵⁹ and third, when an individual has been treated by a psychotherapist under circumstances unrelated to the mental competency issue but now relevant on some other basis.²⁶⁰ In the first instance, the Military Rules of Evidence have made special allowances because of the obvious conflict between absence of a doctor-patient privilege and the constitutional protection against self-incrimination.²⁶¹ Military Rule of Evidence 302 allows the government to obtain access to the only reliable evidence concerning the accused's sanity.²⁶² Simultaneously, restrictions are placed on the use of that evidence to protect the accused's right against self-incrimination.²⁶³

In the second instance, a psychotherapist-patient privilege is normally not an issue when the accused first offers the evidence at trial. In that case, he has opened the door to his mental competency and waived any privilege that arguably existed.²⁶⁴ The psychotherapist-patient privilege could apply, however, when the accused does not open the door and the government attempts to introduce such evidence anyway.²⁶⁵

Finally, the third instance presents the situation most likely to implicate a psychotherapist-patient privilege. Once an individual has sought treatment from a civilian or military psychotherapist, those subsequent communications and records are subject to disclosure in a military court, unless privileged in some way.²⁶⁶ The greatest fears of privacy advocates are threatened

in this instance. Clearly, no skeleton buried in the closet is safe from a military court-martial once discussed in a psychotherapeutic relationship. Additionally, proponents of the utilitarian theory would submit that the harm to individuals from these disclosures would far outweigh any benefits accorded to the pursuit of truth in a court-martial.

B. THE MILITARY RULES OF EVIDENCE

1. GENERALLY

Since 1950, military courts have been statutorily directed to conform their procedures and modes of proof, to principles of law and rules of evidence recognized in federal criminal trials.²⁶⁷ A majority of the Military Rules of Evidence were, therefore, subsequently adopted with minor modifications from the Federal Rules of Evidence.²⁶⁸ One major difference, however, was section V concerning privileges. The federal privilege section was consolidated into a general rule, FRE 501.²⁶⁹ The military privilege section, however, combined a general rule of privilege with specific rules drawn from the proposed Federal Rules and the 1969 Manual.²⁷⁰ The only specific privilege rules adopted from the Proposed Federal Rules were generally the noncontroversial ones: The general rule,²⁷¹ lawyer-client,²⁷² communications to clergy,²⁷³ husband-wife,²⁷⁴ identity of informant,²⁷⁵ and political vote.²⁷⁶ Large scale adoption of the Proposed Federal Rules was believed necessary to provide specific guidance and stability to military law.²⁷⁷ The Military Rules of Evidence parallel the Federal Rules of Evidence, but do not duplicate them.²⁷⁸ Several factors result in this approach. Contrary to the federal Article III court system, the military legal system includes many nonlawyers, uses temporary facilities, and is burdened with worldwide geographical and personnel instability.²⁷⁹ The drafters' underlying message in this formulation is to keep the privilege rules simple.²⁸⁰

2. MILITARY RULE OF EVIDENCE 501

If there is to be a psychotherapist-patient privilege in military courts-martial, it will have to be based on Military Rule of Evidence 501.²⁸¹ Specifically, subparagraph (a)(4) allows the military court to accept a privilege if required by or provided for in the common law principles recognized in federal criminal cases pursuant to FRE 501.²⁸² This provision, of course, is subject to several limitations. The privilege rule must be logically applicable to the military and not inconsistent with the UCMJ, the Military Rules of Evidence, or the Manual.²⁸³ That could be considered a substantial threshold to overcome, yet the Army Court of Military Review did just that in United States v. Martel.²⁸⁴ In Martel, the accused was convicted of larceny, housebreaking and presenting a false dependent travel claim.²⁸⁵ Evidence at trial included several communications made to the accused's spouse that allegedly came within the husband-wife privilege.²⁸⁶ The court analyzed the communications under Rule 504, resolving "any deficiencies or ambiguities... by interpreting and applying those federal common law principles which seem, in the light of [the court's] reason and experience, most compatible with the unique needs of military due process."²⁸⁷ In other words, the court used the federal common law gap-filler provision of Rule 501(a)(4) to resolve inconsistencies and deficiencies in another section V privilege rule. The court ultimately adopted a common law presumption of confidentiality on all the private communications made between the accused and his spouse, and imposed a burden on the government to overcome the presumption.²⁸⁸

Martel conveys two important points. First, the military appellate courts have authority and are willing to change military evidentiary privilege law to reflect federal practice.²⁸⁹ Second, the law regarding the various privileges was unsettled when the Military Rules of Evidence were adopted.²⁹⁰ The military rules privilege section was drafted to be flexible to respond to the federal common law of privileges. Thus, authority to adopt a

federal common law psychotherapist-patient privilege exists, subject to the limitations mentioned in Rule 501(a)(4).

The most substantial impediment to adopting a psychotherapeutic privilege lies in Rule 501(d).²⁹¹ The provision continues the long standing military practice of nonrecognition of the physician-patient privilege.²⁹² The issue centers on whether adoption of a psychotherapist-patient privilege pursuant to federal common law will be contrary to or inconsistent with Rule 501(d)? If the psychotherapist-patient privilege is narrowly applied, then it will not conflict with the doctor-patient privilege language rejected in the rules. This approach, however, would require the courts to recognize the distinctions between psychotherapists and general practitioners.

3. MILITARY RULE OF EVIDENCE 302

Rule 302 rectifies few of the problems associated with the absence of a physician-patient privilege in military law. The rule provides that the accused could be compelled to submit to a psychiatric examination, should he raise the insanity defense at trial.²⁹³ Statements made by the accused at the compelled examination are privileged at trial from use against him on the issue of guilt or innocence or during sentencing proceedings.²⁹⁴ The privilege extends to derivative evidence discovered through use of those compelled statements.²⁹⁵ Finally, there is no privilege when the accused introduces those statements or derivative evidence.²⁹⁶

Prior to Rule 302's adoption, no such protection existed except by case law.²⁹⁷ Not only was the accused forced to submit to the mental examination before he could raise the insanity defense, but his statements were discoverable by the government.²⁹⁸ Those statements are now explicitly kept from the trial counsel until revealed by the defense.²⁹⁹ The analysis to Rule 302 states that its purpose is to protect the accused's privilege against self-incrimination, rather than create a doctor-patient privilege.³⁰⁰ The privilege does appear to lessen

to some extent the harm to individuals caused by lack of a psychotherapist-patient privilege, but the logic is flawed. Results of compelled mental exams are only admissible when the accused raises the issue. This is similar to the same exception that every state privilege rule includes.³⁰¹ Rule 302 does not protect any statements made by the accused other than at compelled R.C.M. 706 examinations.³⁰² Rule 302 does not prevent the government from using statements made to civilian or military psychotherapist unless ordered pursuant to R.C.M. 706.³⁰³ Therefore, Rule 302 is not as beneficial as it first appeared in determining the need for a psychotherapist-patient privilege in military courts-martial.

4. OTHER MILITARY PRIVILEGE RULES

Support for a psychotherapist-patient privilege in courts-martial can be found in various other privileges recognized in the Military Rules of Evidence. The attorney-client, priest-penitent, and husband-wife privileges are based upon public recognition that the privacy of those relationships are more important than achieving a short range goal by bringing a criminal to justice.³⁰⁴

The attorney-client privilege provides the most far reaching protection to an accused. Rule 502 mirrored Proposed Federal Rule 503.³⁰⁵ Protection under the Military Rules of Evidence was also broadened to include nonlawyer counsels³⁰⁶ and compelled or inadvertent disclosures.³⁰⁷ Firmly grounded in the common law, the privilege extends beyond the attorney-client relationship to include others involved in rendering professional legal services.³⁰⁸

In some cases the privilege could include psychotherapist-patient communications if the therapist were a "representative" of the attorney, and the privilege were not waived by presenting an insanity defense.³⁰⁹ This protection would lessen arguments for a psychotherapist-patient privilege, especially since each soldier has access to a military attorney in

order to initiate the attorney-client relationship first. Extending the attorney-client privilege to compensate for the lack of a psychotherapist-patient privilege, however, creates a piecemeal and uncertain protection at best. Psychotherapeutic relationships entered into under circumstances unrelated to the mental competency issue at trial, or separate from the attorney-client relationship, continue to have no protection under the military rules.³¹⁰

Two reasons for the attorney-client privilege include encouraging a frank and open relationship and representing a client as his alter ego. A third policy reason in support of the attorney-client privilege is that it reflects the lawyer's ethical duty to preserve his client's confidences.³¹¹ Psychotherapists have similar ethical responsibilities to their patients in their professional codes.³¹² Additionally, psychotherapeutic relationships are best able to benefit the patient and society when frank and open discussions are encouraged, much like attorneys.

Communications to clergy, like psychotherapeutic communications were not recognized at common law.³¹³ Like the attorney-client and husband-wife relationships, however, the Military Rules of Evidence recognized that a public advantage "accrues from encouraging free communications" in those relations.³¹⁴ The rule protects only those communications made as a formal act of religion or as a matter of conscience.³¹⁵ Here again, the drafters relied heavily on the Proposed Federal Rules.³¹⁶ The privilege was also expanded from pre-rules law by preventing disclosure by a third party eavesdropper.³¹⁷

The priest-penitent privilege most closely resembles the intimate and personal relationship present in the psychotherapeutic relationship. Indeed, many clergy and their assistants act as secular quasi-psychotherapists part of the time in counseling soldiers.³¹⁸ Yet, those communications may still be privileged if conveyed as a matter of conscience.³¹⁹

The husband-wife privilege of Rule 504, like the attorney-client privilege has its roots firmly based in the common law.³²⁰ It is in essence a two-part rule: The first concerning

the ability of a spouse to testify, the second dealing with confidential communications in the marriage.³²¹ Under the current rule, only the witness spouse has a privilege to refuse to testify.³²²

The frequently cited purpose of the husband-wife privilege was protection of the family relationship.³²³ Under prior rules, protection of that relationship led to unpopular opinions when crimes against family children occurred. In United States v. Massey, the court held that the accused's wife was not the victim in the offense of carnal knowledge with her daughter, therefore, she could not testify after the accused invoked the privilege.³²⁴ Subsequently, the rule was modified to allow the spouse's testimony in cases of child abuse.³²⁵

What is relevant from these facts is that common law rules of evidence can and should be changed when they lose their original value. Experience teaches us that intractable rules based on outdated logic lead to inevitable, inequitable results. Rules of evidence must remain flexible and responsive to the needs of society. When the scales of justice tip too far in one direction, it is time to relook the wisdom of our time honored procedures for developing the truth.³²⁶

Federal cases analyzing the psychotherapist-patient privilege considered, among several factors, the Proposed Federal Rules of Evidence, their legislative history, and state privilege statutes.³²⁷ Military case law reacted along a similar vein. One military panel commented that the Proposed Federal Rules were meant by the Supreme Court for application to federal courts, even though Congress failed to adopt them.³²⁸ In determining whether a couple is separated for purposes of application of the husband-wife privilege under Rule 504, military courts must look to state law.³²⁹ In expanding the breadth of the priest-penitent privilege of Rule 503, the panel in United States v. Moreno examined similar state privilege statutes.³³⁰ More recently, in United States v. Reece, the Court of Military Appeals held that trial courts must weigh state interest in maintaining confidentiality of juvenile records when determining the relevance and necessity

of evidence for cross-examination.³³¹ These cases demonstrate that factors considered by federal district courts analyzing asserted privileges have similar relevance to military privilege law analysis. Military courts confronted with the psychotherapist-patient privilege should be prepared to consider such factors as the Proposed Federal Rule 504, state privilege statutes, federal cases, federal common law, and distinctions between psychotherapists and general physicians.

C. PRIVILEGE BY ARMY REGULATION

As discussed earlier, several federal statutes protect the confidentiality of patients and their medical records when treated for mental illness or drug dependency.³³² It was argued that Congress sought to indirectly change the rules of evidence to protect individuals seeking treatment and rehabilitation.³³³ One statute in particular, 42 U.S.C. sec. 290ee-3(a), reflected a Congressional attempt to combat a national drug problem.³³⁴ Pertinent parts of the statute explicitly required that medical records of patients enrolled in federal drug abuse programs be kept confidential.³³⁵ Congress intended to ensure effective participation and treatment in those programs by removing the threat of subsequent disclosure.³³⁶ The statute did not, however, apply to the armed forces.³³⁷

Public Law 92-129 required that the armed forces implement a program to identify and treat drug and alcohol dependent soldiers.³³⁸ The Army's response was AR 600-85, the Alcohol and Drug Abuse Prevention and Control Program, ADAPCP.³³⁹ The regulation's purpose mirrored that of the federal statute to combat drug and alcohol abuse in the Army.³⁴⁰ The regulation also sought to maintain confidentiality of information concerning soldiers enrolled in the program through its Limited Use Policy.³⁴¹

The policy prevented use of certain information on soldiers in any actions under the Uniform Code of Military Justice, to include courts-martial.³⁴² The information included evidence

obtained through enrollment and participation in the program.³⁴³ It also included evidence relating to emergency medical care, not preceded by an apprehension, of soldiers experiencing a suspected drug or alcohol overdose.³⁴⁴ The policy, however, had two important exceptions. First, it did not extend to criminal acts committed while under the influence of illegal drugs or alcohol or to illegal use or possession of drugs after entry into the program.³⁴⁵ Second, there existed no protection if the acts could have an adverse impact on or compromise the mission, national security, or the health and welfare of others.³⁴⁶ The clear intent of this regulation and its policies was threefold: To protect the privacy and personal confidences of soldiers enrolled in the program;³⁴⁷ to remove any fear of public disclosure of past or present abuse; and to encourage participation in a treatment and rehabilitation program.³⁴⁸

AR 600-85 created a limited medical privilege in military courts-martial. It is a broad privilege in the sense that limited use evidence, in the possession of any member of the military, cannot be disclosed except in a few specific circumstances.³⁴⁹ It is a privilege military courts are willing to apply despite its apparent inconsistency with Military Rule of Evidence 501(d). A defense counsel failed to object to introduction of limited use evidence during sentencing in United States v. Howes.³⁵⁰ The panel set aside the sentence because of ineffective assistance of counsel when the defense counsel failed to object to the trial counsel's improper use of ADAPCP information.³⁵¹ In a footnote, the court stressed that Rule 501(d) condemned doctor-patient privileges bottomed on federal common law only.³⁵² The rule did not prevent soldiers from claiming a privilege provided for by an Act of Congress.³⁵³ Although the court did not specifically state that 42 U.S.C. sec. 290ee-3(a) is "an Act of Congress applicable to trials by court-martial," the inference remains.³⁵⁴

AR 600-85 represents one way social pressures to treat illnesses have penetrated the military structure. The army recognized that in combatting drug abuse, effective punishment of offenders is not the only solution. The military benefits more if

drug abusers can be identified, treated, and rehabilitated. Even those failing rehabilitation still receive some treatment. This approach's success is exceedingly dependent upon the confidentiality provisions of the Limited Use Policy. It serves to point out the inflexibility and outdated nature of the military antimedical privilege position. Psychotherapy, like ADAPCP, serves to treat and rehabilitate soldiers undergoing mental or emotional problems, including drug and alcohol addiction.³⁵⁵ Common sense tells us that often these problems are interrelated. Mental and emotional illnesses are not high profile problems that attract national attention like drug abuse. Regardless of whether a valid basis for adopting a psychotherapist-patient privilege under Rule 501 exists, a solution to the dilemma would most likely originate in a regulatory provision. For example, an Army Regulation could provide that soldiers seeking treatment for mental or emotional conditions desiring confidentiality could enroll in a program similar to ADAPCP. The regulation could allow them to pursue civilian or military mental health care under a quasi-limited use policy. Exceptions to the rule would exist, but its threefold purpose could be met: To protect privacy and personal confidences of soldiers enrolled in the program; to remove any fear of public disclosure of past or present treatment; and to encourage participation in the treatment program.

D. CURRENT TRENDS IN MILITARY LAW

Apart from one opinion previously addressed,³⁵⁶ military case law has remained resolute in reaffirming the absence of a doctor-patient privilege in the Military Rules of Evidence.³⁵⁷ There is also nothing to indicate that the rule will change in the future. While psychotherapy has become a unique and expanding field of medical treatment, military case law has continued to focus on doctor-patient relationships, even when issues involving psychotherapists are involved.³⁵⁸ Certain related modifications have, however, occurred in the Military Rules of Evidence. They implicitly reflect that nonrecognition of the doctor-patient

privilege is too broad a proscription. Privilege rules or equivalent substitutes have been created to resolve the dilemma regarding compelled medical examinations pursuant to R.C.M. 706.³⁵⁹ What additional piecemeal accommodations will occur remains to be seen.

As you may recall, three instances were discussed where psychotherapist-patient communications are normally offered into evidence.³⁶⁰ One involved statements made pursuant to R.C.M. 706 compelled mental examinations. Rule 302 has served to protect to a limited extent the confidentiality of those statements, providing that the accused does not raise the insanity issue.³⁶¹ The rule is not meant to be a doctor-patient privilege, nonetheless, it serves the same purpose.³⁶²

Another instance concerned psychotherapist-patient communications conducted apart from the mental competency issue, but relevant on some other basis. These communications currently have no protection from disclosure in military courts-martial, once discovered. Individuals who privately sought treatment in the past would be subjected to substantial harm by subsequent disclosure. If a military psychotherapist-patient privilege ever exists, the driving force in its creation will, no doubt, originate because of disclosures in this instance.

In the final instance, an accused who retained the services of his own psychotherapist on the issue of mental competency, may subject those communications to forced disclosure, even when sanity is not litigated at trial. The Court of Military Appeals in United States v. Toledo recently looked at this scenario and offered the closest thing to a psychotherapist-patient privilege yet recognized in military law.³⁶³ In Toledo, the accused was charged with various specifications of sexually abusing a naval petty officer's daughter.³⁶⁴ The defense counsel used the services of an Air Force clinical psychologist to determine whether mental competency would be an issue.³⁶⁵ The counsel never requested that the psychologist be appointed to examine the accused or assist in the defense.³⁶⁶ The defense counsel also asked the psychologist to keep all information relating to the

examination "in strict confidence."³⁶⁷ Mental competency was never raised at trial.³⁶⁸ In the government's case-in-rebuttal, the clinical psychologist was called as a witness to testify concerning the accused's character for truth and veracity.³⁶⁹ The trial judge overruled defense objections based on privilege and allowed the government to present the clinical psychologist's devastating testimony.³⁷⁰

The Court of Military Appeals, not surprisingly, ruled that there is no doctor-patient privilege per se under the Military Rules of Evidence.³⁷¹ The court, did, however, examine another alternative for precluding the psychologists' testimony that was neither raised at trial or on appeal, the attorney-client privilege.³⁷² Upon a proper request, the military clinical psychologist could have been assigned to assist the defense team as the defense counsel's representative, thereby falling within the protective umbrella of the attorney-client privilege.³⁷³ Since there was no request, the attorney-client privilege was unavailing.³⁷⁴ On the other hand, if the defense had hired a civilian clinical psychologist, no request would have been necessary to bring him within the privilege.³⁷⁵ Of course, any extension of the attorney-client privilege in this case would have been waived if insanity had been raised.³⁷⁶

The Court seemed to underscore the necessity for a psychotherapist to assist the defense team in dealing with mental competency issues.³⁷⁷ Trial judges will undoubtedly take a hard look at cases where such requests for assistance are denied. Despite the strategic advantages from not requesting such assistance, the defense in Toledo paid a large price for its discretion.³⁷⁸

These three instances represent the sum and substance of how the Military Rules of Evidence treat confidential psychotherapeutic communications. The strong anti-medical privilege bias has proven to be a formidable obstacle against recognizing any psychotherapist-patient privilege. Despite its overbroad nature and outmoded rationale, Rule 501(d) remains valid military evidence law. There is room for a narrow

psychotherapist-patient privilege, contrary to the literal language of the rule, but, there is little chance any change will originate in military case law. Adoption of a psychotherapist-patient privilege is going to require two conditions. First, the perceived need for the privilege will have to be raised, most likely by the civilian and military psychotherapists community. For example, if psychotherapists can demonstrate an impairment of their ability to bring in and effectively treat patients due to lack of confidentiality, the privilege can be better justified. Second, legislative, executive, or regulatory creation of the psychotherapist-patient privilege will have to occur. Military case law is not renown for changing long standing rules of evidence, especially when federal appellate circuits are unable to come to a common view on the legal concept.³⁷⁹ However, adoption of a military psychotherapist-patient privilege rule or creation of a regulation along the lines of AR 600-85, the ADAPCP regulation, will guarantee its application.

V. THE PSYCHOTHERAPIST'S PERSPECTIVE-RESULTS OF A SURVEY

One area not yet considered in this thesis concerns psychotherapist observations. The analysis has so far treated the psychotherapist-patient relationship as an interchangeable concept, affected only by external factors. Inherent in the relation, however, are significant additional elements that can affect the final determination to create a new privilege. Psychotherapists and their patients are influenced by internal factors such as status, ethical and moral obligations, professional responsibilities, behavior modification, and ultimately personal principles. I conducted a modest survey of Army psychiatrists to touch on some of these factors, and hopefully, shed some light on the full range of the dilemma. Before reviewing the survey results, it is necessary to explore the nonfungible nature of the psychotherapist-patient relationship.

A. PSYCHOTHERAPIST-PATIENT RELATIONSHIPS ARE NOT

INTERCHANGEABLE

1. STATUS

Therapist or patient status can bear on the applicability of a privilege in the military. Nonmilitary patients treated by nonmilitary psychotherapists may legitimately believe that their confidential communications are privileged pursuant to state law.³⁸⁰ Yet those communications can be disclosed if the patient subsequently becomes an accused,³⁸¹ witness, or victim³⁸² in a military court-martial. Even if state laws mandate a privilege, they can be ignored.³⁸³ Soldiers may also seek the services of nonmilitary psychotherapists to avoid the perceived increased disclosure risks associated with military health care. There may be some actual protection simply because no government official is aware of it. However, no protection is afforded in the Military Rules of Evidence.³⁸⁴ In any event, state reporting requirements may ultimately alert government authorities of the communications if they concern specific types of behavior.³⁸⁵

Military psychotherapists routinely treat civilian, dependent, and military patients. Legally, there should be no distinctions in the degree in which any patient's records are kept confidential. Yet, some therapists see it differently, maintaining stricter confidentiality of their civilian patient's communications.³⁸⁶ This may be related, in part, to the basic premise of the military in opposing doctor-patient privilege. That is, the privilege is incompatible with the military need to ensure the health and fitness for duty of its personnel.³⁸⁷ Military psychotherapists perceive less impact on military readiness from a civilian dependent's mental or emotional problems than from a military patient's.

2. ETHICAL, LEGAL, AND MORAL CONFLICTS

Psychotherapists are subject to various influences in their profession, both professional and personal. Complying with a

court order to disclose what they consider confidential information is not always a black and white issue. Psychotherapists will be forced to balance the various factors before deciding how to act. In this vein, it is helpful to consider those concerns.

Most psychotherapists, be they psychiatrist or psychologist, adhere to one of the major ethical codes of their professions.³⁸⁸ This includes military psychotherapists as well.³⁸⁹ These codes universally forbid disclosures of confidential information without authority.³⁹⁰ Legally, however, they provide no privilege in military court-martial.³⁹¹ Psychotherapists disillusionment of the legal process, however, may cause them to give their ethical obligations more weight, even when the code contains explicit waiver provisions when required by law.³⁹²

Psychotherapists may also be subject to civil litigation from former patients for breaches of confidentiality to include suits for monetary damage.³⁹³ Basis for liability could include breach of contract, invasion of privacy, breach of fiduciary duty, violation of state privilege laws, or even state licensing requirements.³⁹⁴ Civilian therapists would be more susceptible to this threat, but military therapists disclosing civilian patient confidential communications could experience similar exposure.³⁹⁵ Civil liability exposure would be substantially decreased since disclosure would in most cases be pursuant to court order. At least one state court, however, has held that psychotherapists may be liable for their actions if they voluntarily provide information without first asserting a privilege and then awaiting a court order.³⁹⁶ Sensitivity to civil liability may cause psychotherapists to resist disclosure at every turn, absent a court order.

Psychotherapists, once compelled to disclose patient information, may fear other adverse actions such as reports of ethical violations and attempts to suspend or revoke their license.³⁹⁷ These fears would be groundless in light of a court ordered disclosure, but they would still play on the minds of the psychotherapist. No amount of government or court assurance will completely satisfy their concerns.

Psychotherapists faced with ethical, legal, and personal concerns will be confronted with what one commentator referred to as the "cruel trilemma."³⁹⁸ Under the trilemma, psychotherapists are forced to choose from one of three undesirable results:

- (1) To violate the extraordinary trust imposed upon them by their patient and profession;
- (2) To lie and thereby commit perjury; or
- (3) to refuse to testify, and thereby be held in contempt of court.³⁹⁹

The untenable circumstances have led more than one psychotherapist to have memory lapses during testimony, curtail therapy, keep separate or sparse records, and even fabricate evidence.⁴⁰⁰

B. EMPIRICAL DATA CONCERNING ARMY PSYCHIATRISTS

1. PREVIOUS EMPIRICAL STUDIES

No previous surveys have been done with army psychiatrists addressing privilege. Only one other empirical study to date has directly addressed the psychotherapist-patient privilege.⁴⁰¹ In that study, the authors examined certain assumptions in support of and arguments against the privilege.⁴⁰² They focused on effects of a Texas psychotherapist-patient privilege statute as perceived by therapists, patients, lay people, and judges one year after its enactment.⁴⁰³ The authors ultimately returned a mixed verdict; arguments for and against the privilege appeared overstated because the privilege had actually caused little impact.⁴⁰⁴ Before proceeding further, note that the Texas statute created a privilege for psychotherapists in civil cases only.⁴⁰⁵ Responses would more likely support a privilege against disclosure in a criminal trial where individual liberty is at stake. The study does provide some beneficial information concerning the attitudes of civilian psychotherapists.

Eighty-four civilian psychiatrists, with a median experience of eleven years were questioned as part of the study.⁴⁰⁶ 48%

had been requested to disclose confidence communications in court, although only 15% actually did.⁴⁰⁷ The authors never stated whether this resulted in out of court disclosures or what type of information was elicited. We do know that one psychiatrist avoided disclosing confidential communications by lying.⁴⁰⁸ The authors also revealed that the disclosures resulted in some decreased patient trust, premature termination of the relationship, and one action for malpractice.⁴⁰⁹

17% of the psychiatrists routinely discussed confidentiality with their patients.⁴¹⁰ 18% did so only when legal problems or a courtroom appearance seemed possible.⁴¹¹ When patients asked if their comments would remain confidential, 47% of the psychiatrists said yes unless the patient was dangerous to himself. 22% said they would unless ordered to disclose by a court, and 12% said confidentiality was absolute.⁴¹² The most interesting response concerned psychiatrist's lack of knowledge in this area. 55% were unaware that Texas had a privilege statute.⁴¹³

Based on these responses, the authors concluded that the privilege statute had little impact on the practice of psychotherapy.⁴¹⁴ Ignorance of the statute weighed heavily in that conclusion.⁴¹⁵ The psychiatrists believed only a few patients suffered from the disclosures.⁴¹⁶ This figure is also misleading considering less than half the psychiatrists knew a privilege existed and only 17% routinely told their patients about it. If the patients' expectation of confidentiality is never raised, they are less likely to be upset when disclosure occurs.

2. ARMY PSYCHIATRIST SURVEY

167 questionnaires were sent to essentially every active duty army psychiatrist. 65 responses were returned, amounting to 39% of those surveyed.⁴¹⁷ This figure was not uncharacteristic for survey reponses. The previously discussed Texas study received only 45% of its therapist's questionnaires back.⁴¹⁸ 95% of the army psychiatrists responding were licensed to practice psychiatry in at least one state.⁴¹⁹ They averaged 12 years of

psychiatric practice and approximately 2000 patients during that time.⁴²⁰ When questioned concerning their knowledge of psychotherapeutic privileges in the states where they were licensed and where they currently practice, the results were surprising. 76% answered incorrectly or did not know what privileges they had in the state in which they were licensed.⁴²¹ An even higher number, 84%, incorrectly answered or did not know what privilege, if any, they had where they were practicing.⁴²²

Previously, we learned that every state has a statute requiring psychiatrists to report information regarding child abuse.⁴²³ Two-thirds of the responding army psychiatrists who reside in the continental United States, Hawaii, and Alaska knew that state law in their area required similar reporting.⁴²⁴ An even higher amount, 91% knew of the army requirement to report child abuse, separate from any state statute requirement.⁴²⁵ Given a hypothetical case in which a male patient admitted sexually abusing his daughter, 98% of the respondents indicated they would report the incident to the Army's Family Advocacy Program Officer or the Social Work Service as long as the child was at risk.⁴²⁶ Only 80% would report the incident if the child were removed from the danger before they were notified the abuse had occurred.⁴²⁷ Several respondents identified other acts they would report as well if disclosed. 22% would report patients that were dangerous to themselves or others.⁴²⁸ Only two respondents each indicated they would report elderly or spouse abuse, security risks, treason, homosexual acts, or violations of the UCMJ.

47% of the respondents protect the confidentiality of communications from nonmilitary patients more than they do military patients.⁴²⁹ The rest treat them the same.⁴³⁰ Most of the respondents had testified in one forum or another: 78% in courts-martial, 70% in military administrative proceedings, 39% in state trials, and 30% in federal trials and state administrative hearings.⁴³¹ In all these proceedings, 25% of the respondents had been ordered to reveal confidential information at one time or

another.⁴³² Most of the released information concerned patient competency, 33%, acts of child abuse, 17%, other criminal acts, 17%, truthfulness, 11%, or personal history, 11%.⁴³³

The greatest disparity in responses occurred when the psychiatrists were asked what, if any, advice they gave their patients concerning confidentiality. Most of the respondents told their patients that only a limited privilege existed, 18% said that no privilege existed, and 3% stated that there was an absolute privilege.⁴³⁴ More specifically, 25% told their patients that commanders had access if they had a need to know.⁴³⁵ 21% said that a court can subpoena information while 20% gave no advice at all unless an issue arose.⁴³⁶ 5% warned that they must report acts dangerous to patients and others.⁴³⁷ The best advice was given by about 10% of the respondents who had their patients read and sign a preprinted form, explaining the limits of confidentiality, prior to any treatment.⁴³⁸ It served to insure accurate, consistent advice was given, memorialized the notice, and removed any lingering doubts about the full extent of confidentiality. Almost every respondent adhered to one or more professional ethical codes, the most popular being the American Psychiatric Association's ethical standards, 67%.⁴³⁹ Contrary to the civilians in the Texas study, most army psychiatrists knew they had no privilege in a federal court, 77%, or in a court-martial, 85%.⁴⁴⁰

By far, the most significant results of the survey concerned what impact the lack of a privilege had on the psychiatrist's ability to treat patients. 74% said that absence of a privilege in the military had little or no impact.⁴⁴¹ The rest perceived a significant effect.⁴⁴² But this may be misleading. The specter of a deeper impact was raised by comments included in their assessment. Two respondents said there was no impact because they warned their patients beforehand.⁴⁴³ Two others claiming no impact asked commanders to not require their testimony whenever possible.⁴⁴⁴ Several respondents, who indicated little impact, did admit that it limited the extent of their inquiries.⁴⁴⁵

Many respondents found lack of confidentiality most damaging when discussing homosexuality with patients.⁴⁴⁶

Those respondents claiming a significant impact provided the most revealing comments. Some stated that they do not solicit damaging information or avoid recording incriminating comments in medical records.⁴⁴⁷ Still others indicated that lack of a privilege was a very serious drawback to military psychiatry because it precluded effective therapy.⁴⁴⁸ Patients, especially officers, reportedly avoided military medical health care because of the lack of confidentiality.⁴⁴⁹

Finally, 70% of the responding army psychiatrists perceived a greater need for confidentiality of communications for psychotherapist than for physicians regarding patient communications.⁴⁵⁰ 72% favored a privilege in military courts-martial for psychotherapist-patient communications similar to what currently exists for attorneys and clergy.⁴⁵¹

3. RESULTS OF THE SURVEY

Responses to the questionnaire indicated that there has been a direct impact on one in four army psychiatrists who were forced to disclose confidential information. This is certainly higher than reported among civilian psychiatrist in the Texas study. It may also reflect that government psychiatrist are more likely to be in a position to testify concerning patients. Army psychiatrists also have other responsibilities in addition to their patients and themselves. As army officers, they are instilled with the responsibility to help maintain the fitness and welfare of the armed forces. Their duty to the military may supersede the duty to their patient in some cases.

The survey responses raised serious questions about the respondents' knowledge of privilege rules in their state of license or where they practiced. Lack of knowledge regarding privilege or reporting requirements could lead to conflicts with local authorities. The rules are normally very simple and could be made available nationwide with minimal effort. The major

disservice from this lack of knowledge concerned warnings made to patients. There appears to be no army-wide policy on what psychiatrists should warn their patients before hand. Although, most respondents were aware they had no privilege in federal or military trials, few conveyed this knowledge. The hodgepodge of responses demonstrated little concern in this area. Patients may unwittingly tell more than they would if properly warned.

What is most evident in the responses is the impact that absence of a privilege has on the psychiatrist-patient relationship. Although most of the respondents indicated that they experienced little or no effect from the situation, by and large, their comments controverted that. Many of them adjusted the structure of their relationships to adopt to the situation, for example; recording less information, seeking to avoid testimony, or limiting inquiries. Others noticed less use of military medical health care, especially by officers. Unlike the Texas study where 55% of the civilian psychiatrists were unaware of the civil privilege, most army psychiatrists know their privilege status. This knowledge has evidently affected to a noticeable degree their ability to treat soldiers in the military.

VI. CONCLUSIONS

The psychotherapist-patient privilege has become a popular subject of debate in evidence law. Growing acceptance of the profession in society attests to its vitality. It has become one area in which the scales of justice are tipping away from the persistent search for truth, leaning instead towards protecting the privacy and sanctity of a relationship dependent upon trust and confidentiality. The psychotherapist, unlike the general practitioner, contributes to society only so long as society is willing to accomodate him in return. If society will protect the confidentiality of the psychotherapeutic relationship, the psychotherapist can effectively treat and rehabilitate those citizens experiencing mental, emotional, or chemical dependency problems.

Time honored common law concepts pertaining to physicians are overstated and outdated when applied to psychotherapists. The distinctions between the professions merit new analysis. Indeed, many modern commentators agree that the psychotherapist-patient privilege should be recognized.⁴⁵²

The psychotherapist-patient privilege is supported by the two major privilege theories in vogue today. The privilege satisfies the fundamental requirements of Dean Wigmore's utilitarian analysis. It also protects the privacy of confidential communications in a necessarily intimate and personal relationship.

The Supreme Court provided another strong argument for its approval when the Court endorsed the privilege in Proposed Rule 504. Their endorsement reflected more than mere approval of a privilege rule. It expressed recognition that the privacy and confidentiality of the psychotherapist-patient relation had reached a higher level of consequence than in the more routine physician-patient relationship.

Federal courts have given a mixed reception to the rule, but the better reasoned opinions, the ones distinguishing psychotherapy from general medicine, have recognized the psychotherapist-patient privilege.⁴⁵³ They relied to varying degrees on both the utilitarian and privacy privilege theories, Proposed Rule 504, FRE 501, and state law. Federal drug and alcohol abuse, and mental health care statutes have also created provisions with an effect similar to the psychotherapeutic privilege. Their thrust is to identify and treat those needing help, not to ferret out information for subsequent disclosure.

State law presented a clear indication of the social approval achieved by the psychotherapeutic privilege. The states have faced the problem, responding with their own privilege rules and exceptions, contrary to the hesitancy displayed by Congress. Only two states currently lack some form of psychotherapeutic privilege.⁴⁵⁴

Where privileges are recognized, they are not absolute. Common exceptions to psychotherapist-patient privileges include hospitalization proceedings, court ordered examinations, cases in

which a patient makes his condition an element of his claim or defense, and incidents of suspected child abuse.

The Military Rules of Evidence have demonstrated little desire to accept the privilege, despite favorable receptions in other jurisdictions. Military case law has even failed to seriously consider the distinctions between psychotherapists and physicians. Ensuring the health and fitness for duty of personnel is no longer valid justification to not recognize this limited medical privilege. Recent changes in army policy reflect this reprioritization: R.C.M. 706 has been changed to elevate clinical psychologists to a credibility level equivalent to psychiatrists;⁴⁵⁵ AR 600-85 has ostensibly created a regulatory medical privilege for soldiers undergoing drug and alcohol abuse rehabilitation, despite the explicit language of FRE 501(d).⁴⁵⁶

Current alternatives to the psychotherapist-patient privilege are inadequate. Military Rule of Evidence 302 protects only those statements made in compelled mental examinations.⁴⁵⁷ This is waived, as in most state statutes, when the accused raises the mental competency issue.⁴⁵⁸

The military attorney-client privilege of Rule 502, alluded to in United States v. Toledo, provides some relief, but only applies to situations where defense counsels employ psychotherapists.⁴⁵⁹ No protection exists for confidential communications made in situations not involving compelled examinations or shielded by the attorney-client privilege.

Military courts can not be expected to create a psychotherapist-patient privilege pursuant to the federal common law, notwithstanding these concerns, .⁴⁶⁰ The Department of the Army or some higher authority must provide regulatory, legislative, or executive relief before any change will occur in military courts.

The army psychiatrist's survey revealed several remarkable facts. Most military psychiatrists know they have no privilege, yet few convey this fact to their patients. This may explain why the psychiatrists perceive no, or only a limited effect on their treatment of patients. Beneath the surface, however, evidence

indicates that therapy is, indeed, hindered. Soldiers are not being treated as effectively, if at all, under the current scheme. Military psychiatrists are prevented from treating the mental and emotional problems of our soldiers as effectively as they could. Army psychiatrists are faced with moral, ethical, and legal dilemmas because of the separate interests at stake. Many avoid the problem altogether by taking measures that undermines therapy. Avoiding sensitive issues in therapy, modifying record keeping practices, or scaring away patients adds little to the fitness and welfare of our soldiers. Our current evidence rules, however, produce that undesirable result. It is ironic that the military's antimedical privilege position, considered necessary to ensure the health and fitness for duty of its personnel, creates the opposite effect.⁴⁶¹

VII. RECOMMENDATIONS

A psychotherapist-patient privilege should be applied to military courts-martial. It could be applied in the form of an army regulation or a new Military Rule of Evidence.

An army mental health regulation, similar to the alcohol and drug abuse regulation of AR 600-85, would produce the best solution. It would prescribe a program for identification, treatment and rehabilitation of military personnel. The proposed regulation would allow only limited use of confidential communications originating in the psychotherapeutic relationship. Those circumstances would include those commonly accepted plus exceptions necessary to the armed forces. For example, the limited use policy could be waived in cases posing a threat to the national security or in instances of suspected child abuse. The proposed army regulation could grant trial court's discretion in rare instances to abrogate the protection when necessary for the proper administration of justice.

Alternatively, a new Military Rule of Evidence should be created.⁴⁶² It could be adopted in substantial part from the 1972 draft of the Proposed Federal Rule 504.⁴⁶³ The new rule should

preclude inclusion of general physicians under the definition of psychotherapists. Therapy for drug and alcohol addiction would be considered psychotherapy to reflect the army's policies inherent in AR 600-85. Exceptions would be remain consistent with current rules. For example, a provision excluding statements made pursuant to compelled mental examinations would be duplicitous with Rule 302. Language reflecting the civil law nature of the Proposed Rule 504 would also be deleted. Finally, three new exceptions would be necessary to address modern social issues and the unique nature of the military. These exceptions would include incidents of suspected child abuse, threats to national security, and situations where disclosure is necessary for the proper administration of justice.

The proposed army regulation or evidence rule would serve two important functions in the military. First, they would fill a void in confidentiality of psychotherapist-patient relations that has lessened the army's ability to identify, treat, and rehabilitate soldiers suffering mental or emotional problems. Second, they would codify and simplify a rule of privilege consistent with the approach taken when the other specific military privileges were adopted.⁴⁶⁴ In other words, specific guidance as to what communications were or were not privileged would be provided to assist the nonlawyers involved in military justice worldwide.

ENDNOTES

¹ Hearings-Before The Special Subcomm. On Criminal Justice of The House Subcomm. On The Judiciary, 93d Cong., 1st Sess. 463 (Comm. Print 1973) (Proposed Rules of Evidence) [hereinafter cited as Hearings]; C. Wright and K. Graham, Federal Practice and Procedure: Evidence sec. 5422, at 690 (1980) [hereinafter cited as Wright: Evidence].

² Oldham, Privileged Communications in Military Law, 5 Mil. L. Rev. 17 (1959); 8 J. Wigmore, Evidence, sec. 2196 at 111 (McNaughton rev. 1961) [hereinafter cited as 8 Wigmore]; Wright: Evidence, supra note 1, at 676-85; see also J. Weinstein and M. Berger, 2 Weinstein's Evidence, sec. 501(01), at 501-13 (1985) [hereinafter cited as Weinstein, Evidence] (discussing the views of the Advisory Committee in drafting the Federal Rules of Evidence).

³ C. McCormick, Evidence, sec. 77 at 156-57, 59 (2d ed. 1972) [hereinafter cited as McCormick]; 8 Wigmore, supra note 2, sec. 2286 at 532; Wright, Evidence, supra note 1, sec. 5422 at 676. See Developments in the Law-Privileged Communications, 98 Harv. L. Rev. 1480, 1493 (1985) [hereinafter cited as Developments] (describing the power theory as one basis for privileges); Krattenmaker, Testimonial Privileges in Federal Courts: An Alternative to the Proposed Federal Rules of Evidence, 62 Georgetown L.J. 61, 85 (1973) [hereinafter cited as Krattenmaker].

⁴ J. Munster and M. Larkin, Military Evidence (2d ed. 1978).

⁵ Saltzburg, Privileges and Professionals: Lawyers and Psychiatrists, 66 Va. L. Rev. 597 (1980).

⁶ This is demonstrated by Section V of the Manual for Courts-Martial, United States, 1984 [hereinafter cited in text and footnotes as MCM or Manual]. Currently eight specific privileges are enumerated in addition to the general rule, Mil. R. Evid. 501. Additional privileges are located in Mil. R. Evid. 301, 302, and 303. See S. Saltzburg, L. Schinasi, and D. Schlueter, Military

Rules of Evidence Manual at 415 (2d ed. 1986) [hereinafter cited as Saltzburg, Evidence].

⁷ MCM, United States, 1969 (Rev. ed.), para. 151C; Mil. R. Evid. 501(d) which provides:

Notwithstanding any other provision of these rules,
information not otherwise privileged does not become
privileged on the basis that it was acquired by a medical
officer or civilian physician in a professional capacity.

[hereinafter cited as Mil. R. Evid. 501(d)]; see also Mil. R. Evid. 501 analysis; W. Winthrop, Military Law and Precedents 332 (2d ed. 1920) [hereinafter cited as Winthrop].

⁸ MCM, Mil. R. Evid. 501 analysis; Saltzburg, Evidence, supra note 6 at 416.

⁹ 25 M.J. 274 (C.M.A. 1988).

¹⁰ Id. at 275.

¹¹ Id. at 275.

¹² Id.

¹³ This definition is derived in part from the 1971 and 1972 drafts of the Proposed Federal Rule of Evidence, Rule 504 [hereinafter cited as Proposed Rule 504], 51 F.R.D. 315, 366 (1971); 56 F.R.D. 183, 240 (1972).

¹⁴ This definition is similar to the 1971 draft of the Proposed Rule 504, 51 F.R.D. 315, 366. See also Developments, supra note 3, at 1540 (describing how all state statutes concerning psychotherapist-type privileges limit application to those meeting professional licensing standards).

¹⁵ The subsequent 1972 draft of the Proposed Rule 504, expanded the definition even further to include general practitioners treating mental or emotional conditions including drug addiction, and unlicensed therapists engaged in psychotherapeutic aid. 56 F.R.D. at 240-243. These changes to the original draft of Proposed Rule 504 will be discussed later.

¹⁶ See, e.g., The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, sec. 9, 130 Am. J. Psychiatry, 1058, 1059 (1973); Ethical Principles of Psychologists, 36 Am. Psychologist 633, 635-636 (1981).

- ¹⁷ See, e.g., Appendix C, infra, para. (a)(3).
- ¹⁸ MCM, 1984, Mil. R. Evid. 501.
- ¹⁹ 8 Wigmore, supra note 2, sec. 2380 at 818; McCormick, supra note 3, sec. 98 at 212; 2 D. Louisell and C. Mueller, Federal Evidence, sec. 215 at 839 (Rev. 1985) [hereinafter cited as 2 Louisell]; Whalen v. Roe, 429 U.S. 589, 602 n. 28 (1977).
- ²⁰ Dutchess of Kingston's Trial, 20 How. St. Tr. 355, 573 (1776).
- ²¹ 8 Wigmore, supra note 2, sec. 2380 at 819; McCormick, supra note 3, sec. 98 at 212; M. Larkin, Federal Testimonial Privileges, sec. 3.01 at 3-1 (1984) [hereinafter cited as Larkin, Privileges].
- ²² Appendix A, infra; Developments, supra note 3, at 1532-1536.
- ²³ 56 F.R.D. at 242 (Advisory Committee's note to the 1972 draft of the Proposed Rule 504); See also Psychotherapist-Patient Privilege under Federal Rule of Evidence 501, 75 J. Crim. L. and Criminology, 388, 395 (1984) [hereinafter cited as Psychotherapist-Patient Privilege].
- ²⁴ This type of argument has also been characterized as 'pragmatic', 2 Louisell, supra note 19, sec. 201 at 655; 'instrumental', Wright: Evidence, supra note 1, sec. 5422 at 670-671; and 'traditional' Developments, supra note 3, at 1472.
- ²⁵ Wright: Evidence, supra note 1, sec. 5422 at 671.
- ²⁶ C. Wright and K. Graham, Federal Practice and Procedure: Evidence, sec. 5422.1 at 144 (Supp. 1987) [hereinafter cited as Wright: Evidence Supp.].
- ²⁷ 8 Wigmore, supra note 2, sec. 2285 at 527. See also Developments, supra note 3, at 1472
- ²⁸ Id.; see also Wright: Evidence, supra note 1, sec. 5422 at 671 (discussing the instrumental justification for privileges); 2 Louisell, supra note 19, sec. 201 at 655-656.
- ²⁹ 8 Wigmore, supra note 2, sec. 2285 at 527 and sec. 2380a at 828-832.
- ³⁰ 8 Wigmore, supra note 2, sec. 2380a at 829.
- ³¹ Id.
- ³² Id., sec. 2285 at 528. Contra, 2 Louisell, supra note 19, sec. 201 at 656 (He believes the four criterion support a

psychotherapist-patient privilege and substantially supports at least a limited physician-patient privilege.

³³ 8 Wigmore, supra note 2, sec. 2380a at 830.

³⁴ Louisell, Confidentiality, Conformity and Confusion: Privileges in Federal Court Today, 31 Tul. L. Rev. 101, 111 (1956) [hereinafter cited as Louisell, Confidentiality]. See also Developments, supra note 3, at 1474-1479 (discussing the problems with any empirical analysis).

³⁵ Shuman and Weiner, The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege, 60 N.C.L.Rev. 893 (1982) [hereinafter cited as Shuman]; Note, Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine, 71 Yale L.J. 1226 (1962).

³⁶ Louisell, Confidentiality, supra note 34, at 111; Saltzburg, Privileges and Professionals: Lawyers and Psychiatrists, 66 Va. L. Rev. 519, 618-620 (1980) [hereinafter cited as Saltzburg, Privileges].

³⁷ 2 Louisell, supra note 19, sec. 201, at 655-656; see Psychotherapist-Patient Privilege, supra note 23, at 391-394; Note, The Case for a Federal Psychotherapist-Patient Privilege that Protects Patient Identity, 1985 Duke L.J. 1217, 1223 [hereinafter cited as Case for a Privilege]; Shuman, supra note 35, at 905.

³⁸ Developments, supra note 3, at 1480-1483; see Louisell, Confidentiality, supra note 34, at 101; Saltzburg, Privileges, supra note 36, at 616-625; McCormick, supra note 3, sec. 77 at 157; see also Wright: Evidence, supra note 1, sec. 5422 at 671-672 (Characterizing the privacy theory as non-instrumental); 2 Louisell, supra note 19, sec. 201 at 655 (endorsing Dean Wigmore's pragmatic approach for privileges dealing with professional relationships, but emphasizing the need to consider underlying values equally if not more); cf. Wright: Evidence Supp., supra note 26, at 145 (It is wrong to suppose that a privacy argument is necessarily noninstrumental).

³⁹ Louisell, Confidentiality, supra note 34, at 110.

40 Id.

41 McCormick, supra note 3, sec. 72 at 152.

42 2 Louisell, supra note 19, sec. 201 at 655; see Wright:
Evidence, supra note 1, sec. 5422 at 672.

43 Saltzburg, Privileges, supra note 36 at 601 (his two part test
provides:

Part I-Nonlitigation values:

(1) Does the privilege concern a personal relationship
or subject that traditionally has received special
solicitude from government?

(2) Has this solicitude involved respect for the
privacy of the relationship or information?

(3) Would reasonable persons asked to provide the
information find the relationship threatened by
disclosure, or result by disclosure in an unwarranted
adverse affect on the person making the privacy claim?

(4) Is the relationship or privacy claim, though
traditional, still valued today?

If the answer to (1)-(4) is yes, then proceed to Part II.

Part II-Litigation values:

(1) Does the privilege conceal evidence otherwise
available to the court?

(2) If so, is this lost information an acceptable price
to pay for nonlitigation gains?);

see also Developments, supra note 3, at 1480 n. 53 (describing
how some commentators place privileges into 2 categories; some
justified by the privacy theory and others by the traditional
utilitarian approach).

44 Developments supra note 3, at 1484.

45 Wright: Evidence, supra note 1, sec. 5422 at 672-673.

46 Developments, supra note 3, at 1482; see Saltzburg,
Privileges, supra note 36, at 601.

47 Developments, supra note 3, at 1483.

48 Id., at 1483 n. 77; cf. Wright: Evidence, supra note 1, sec.
5422 at 673 (arguing that any noninstrumental analysis cannot be
proved or disproved by any empirical data).

49 Developments, supra note 3, at 1493.

50 Id.

51 Wright: Evidence, supra note 1, sec. 5422 at 675-677;
McCormick, supra note 3 sec. 77 at 159; 8 Wigmore, supra note
2, sec. 2286, 2380a at 532, 831; E. Green and C. Nesson,
Problems, Cases, and Materials on Evidence 522, 526 (1983); cf.
Wright: Evidence Supp., supra note 26, at 148.

52 Appendix A, infra (demonstrates how members of the medical
profession have generally received some form of testimonial
privilege by most states); Wright: Evidence, supra note 1, sec.
5422 at 675-676.

53 Wright: Evidence, supra note 1, sec. 5422 at 676 (citing a
cynic who's identity was claimed to be privileged); Developments,
supra note 3, at 1450.

54 M. Guttmacher & H. Weihofen, Psychiatry and the Law, 270
(1952) [hereinafter cited as Guttmacher].

55 Id. at 271.

56 R. Slovenko, Psychotherapy, Confidentiality, and Privileged
Communication, 42 (1966) [hereinafter cited as Slovenko];
Weinstein, Evidence, supra note 2, sec. 504(03) at 504-15, 16.

57 Slovenko, supra note 54, at 43.

58 8 Wigmore, supra note 2, sec. 2380a at 829. Someone seeking
treatment for a venereal disease might disagree.

59 Slovenko, supra note 54, at 39; Case for a Privilege, supra
note 37, at 1224; 56 F.R.D. at 242 (Advisory Committee Notes to
Proposed Rule 504 quoting Report No. 45, Group for the
Advancement of Psychiatry 92 [1960]); Note, Confidential
Communications To A Psychotherapist: A New Testimonial
Privilege, 47 Nw. U. L. Rev. 384, 386 (1952) ("Like the
confessional, psychotherapy by its very nature is worthless
unless the patient feels assured from the outset that whatever he
may say will be forever kept confidential."); cf. Developments,
supra note 3, at 1531.

60 Slovenko, supra note 56, at 39.

61 Mil. R. Evid. 503(a).

62 Supra note 28; see supra notes 24-37 and accompanying text.

⁶³ Guttmacher, supra note 54, at 272-273; Taylor v. United States, 222 F.2d 398, 401 (D.C. 1955).

⁶⁴ Louisell, The Psychologists in Today's Legal World(Pt II, Confidential Communications), 41 Minn L. Rev. 731, 745-746 (1957).

⁶⁵ Guttmacher, supra note 54, at 272 ("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. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition.").

⁶⁶ Slovenko, supra note 56, at 40.

⁶⁷ Guttmacher, supra note 54, at 272-273.

⁶⁸ Slovenko, supra note 56, at 43-44.

⁶⁹ Id. at 46.

⁷⁰ Whalen v. Roe, 429 U.S. at 602 ("Unquestionably, some individuals' concern for their own privacy may lead them to avoid or to postpone needed medical attention.").

⁷¹ In Re Zuniga, 714 F.2d 632, 639 (6th Cir.), cert. denied, 104 S.Ct. 426 (1983); Psychotherapist-Patient Privilege under Rule 501, supra note 23, at 393; Case for a Privilege, supra note 37 at 1225.

⁷² Slovenko, supra note 56, at 47; Case for a Privilege, supra note 37, at 1225-1226.

⁷³ Slovenko, supra note 56, at 47.

⁷⁴ Id. at 46.

⁷⁵ Supra notes 38-48 and accompanying text.

⁷⁶ Id.

⁷⁷ Griswold v. Connecticut, 381 U.S. 479 (1965) (recognizing a right of marital privacy).

⁷⁸ Whalen v. Roe, 429 U.S. 589, 599 (1977); cf. Nixon v. Administrator of General Services, 433 U.S. 425 (1974) (directing the General Services Administrator to take control of ex-President Nixon's papers and tapes).

- ⁷⁹ Roe v. Wade, 410 U.S. 113 (1973); Carey v. Population Services International, 431 U.S. 678 (1977); Whalen v. Roe, 429 U.S. at 600; Loving v. Virginia, 388 U.S. 1 (1967).
- ⁸⁰ Katz v. United States, 389 U.S. 347, 359 (1967).
- ⁸¹ Rochin v. California, 342 U.S. 165, 173-174 (1952) (forcibly pumping a suspect's stomach violated due process); see also Developments, supra note 3, at 1545-1548 (detailed analysis of the constitutional recognition of privacy interests in these areas); cf. Schmerber v. California, 384 U.S. 757, 766-772 (1966) (a compulsory blood test did not violate the right of privacy).
- ⁸² United States v. Karo, 468 U.S. 705 (1984); Payton v. New York, 445 U.S. 573 (1980); see also Bowers v. Hardwick, 106 S.Ct. 2841, 2850-51 (1986) (Blackmun, J., dissenting) (privacy right did not extend to homosexual conduct in the home).
- ⁸³ Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).
- ⁸⁴ In Re Lifschutz, 2 Cal. 3d 415, 431-432, 467 P.2d 557, 567, 85 Cal. Rptr. 829, 839 (1970) (California Supreme Court stated that the state evidence code and a federal constitutional right to a "zone of privacy" protects psychotherapist-patient communications); In Re B, 482 Pa. 471, 484, 394 A.2d 419, 425 (1978) (the psychotherapist-patient privilege is grounded on the federal and state constitutions).
- ⁸⁵ Winslade and Ross, Privacy, Confidentiality, and Autonomy in Psychotherapy, 64 Neb. L. Rev 578, 598-599 (1985).
- ⁸⁶ S. Rep. No. 1277, 94th Cong., 2d Sess. 4, reprinted in 1974 U.S. Code Cong. & Admin. News 7051, 7058-7059 [hereinafter cited as S. Rep. No. 1277].
- ⁸⁷ In Re Zuniga 714 F.2d 632 (6th Cir.), cert. denied, 464 U.S. 983 (1983); United States v. Meagher, 531 F.2d 752 (5th Cir.), cert. denied, 429 U.S. 853 (1976); Flora v. Hamilton, 81 F.R.D. 576, 579 (M.D.N.C. 1978).
- ⁸⁸ 42 U.S.C.A. sec. 290ee-3 (West Supp. 1987) (drug abuse prevention); 42 U.S.C.A. sec. 242a (West 1982) (mental health research).
- ⁸⁹ Larkin, Privileges, supra note 21, sec. 3.03 at 3-7 (1984).

⁹⁰ See, e.g., Alaska R. Evid. 504 (1979 & 1988 amend.); Hawaii R. Evid. 504 (1985); N.M.R. Evid. 504 (1986).

⁹¹ S. Rep. No. 1277, supra note 86, at 7051.

⁹² Id. at 7052.

⁹³ Id. at 7053.

⁹⁴ Id. at 7058 (Proposed Federal Rule of Evidence 504)

[hereinafter cited as Proposed Rule 504] (The other eight listed privileges included required reports, lawyer-client, husband-wife, communications to a clergyman, political vote, trade secrets, secrets of state and other official information, and identity of informer).

⁹⁵ Id. at 7052; see supra note 13-15 and accompanying text.

⁹⁶ S. Rep. No. 1277, supra note 84, at 7053.

⁹⁷ Id.

⁹⁸ Id.; Fed. R. Evid. 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.

[hereinafter cited as FRE 501].

⁹⁹ Federal Rules of Evidence, Pub. L. No. 93-595, 88 Stat. 1926, 1933 (1975).

¹⁰⁰ S. Rep. No. 1277, supra note 84, at 7059; In Re Zuniga, 714 F.2d at 632, 637; Appendix A, infra.

¹⁰¹ 56 F.R.D. at 240 (The rule provides:

(a) DEFINITIONS.

(1) A "patient" is a person who consults or is examined or interviewed by a psychotherapist.

(2) A "psychotherapist" is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.

(3) A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

(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 so to do is presumed in the absence of evidence to the contrary.

(d) EXCEPTIONS.

(1) Proceedings for hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

(2) Examination by order of judge. If the judge orders an examination of the mental or emotional condition of the patient communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.

(3) Condition an element of claim or defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.

102 Id. at 242 (Advisory Committee's Notes quoting Report No.

45, Group for the Advancement of Psychiatry 92 (1960)

103 Weinstein, Evidence, supra note 2, sec. 504(02) at 504-11.

104 Id. at 504-12 to 504-14 (The 1969 draft of the rule required physicians to devote a substantial portion of their time to psychotherapy).

105 Supra note 101 at para. (a)(2).

106 Weinstein, Evidence, supra note 2, sec. 504(02) at 504-12.

107 Compare, Mil. R. Evid. 502 (Lawyer-client) and Mil. R. Evid. 503 (Communications to clergy).

108 Supra note 101 at para. (d).

109 Mil. R. Evid. 302 prevents disclosure of any statements made by an accused during a mental examination ordered pursuant to

the MCM, 1984, Rule for Courts-Martial 706 [hereinafter cited as R.C.M. 706].

110 Louisell, supra note 19, sec. 201 at 668-670.

111 Id.

112 S. Rep. No. 1277, supra note 86 at 7053.

113 S. Saltzburg and K. Redden, Federal Rules of Evidence Manual, 231 (3d ed. 1982) (editorial explanatory comment) [hereinafter cited as Saltzburg, Federal Evidence].

114 Hearings, supra note 1, at 449-450 (Patricia Wald testifying).

115 Id.

116 Id.

117 120 Cong. Rec. 1409 (1974) (Representative Dennis was the author of the quote that began this thesis).

118 S. Rep. No. 1277, supra note 86, at 7053.

119 See Hearings, supra note 1 at 546-578.

120 S. Rep. No. 1277, supra note 86, at 7058; 28 U.S.C.A. 1332 (West Supp. 1987); Erie v. Tompkins, 304 U.S. 64 (1938).

121 S. Rep. No. 1277, supra note 86, at 7059.

122 Id.

123 See supra note 98.

124 H.R. Rep. No. 650, 93d Cong., 2d Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 7075, 7082 [hereinafter cited as H. Rep. No. 650].

125 S. Rep. No. 1277, supra note 86, at 7058; cf. 120 Cong. Rec. 1409 (1974) (a member of the subcommittee that drafted FRE 501 to replace the 13 enumerated rules stated that evidence privileges were matters of substantive law that should be left to the states).

126 Id.

127 Id.

128 Id.; Trammel v. United States, 445 U.S. 40, 47 (1980)

(application of FRE 501 to the marital privilege); S. Rep. No. 1277, supra note 86, at 7058.

129 Trammel, 445 U.S. at 47.

130 Saltzburg, Federal Evidence, supra note 113, at 229.

131 S. Rep. No. 1277, supra note 86, at 7059.

- 132 Supra note 98.
- 133 Id.; In Re Pebsworth, 705 F.2d 261, 262 (7th Cir. 1983).
- 134 Id.
- 135 United States v. Crews, 781 F.2d 826, 831 (10th Cir. 1986) (defendant waived any potential psychotherapist-patient privilege); In Re Doe, 711 F.2d 1187, 1193 (2d Cir. 1983) (no real psychotherapist-patient relationship existed); United States v. Alvarez, 519 1036, 1046 n.13 (3d Cir. 1075) (treatment of the accused by a psychiatrist was to assist the defense counsel, not for purpose of diagnosis or treatment); United States Ex Rel. Edney v. Smith, 425 F. Supp. 1038, 1044 (the psychiatrist-patient privilege, if any, did not apply to the facts of the case); see Annotation, Psychotherapist-Patient Privilege Under Federal Common Law, 72 A.L.R. Fed. 395 (1985).
- 136 United States v. Lindstrom, 698 F.2d 1154, 1167 n.9 (11th Cir. 1983); United States v. Meagher, 531 F.2d 752, 753 (5th Cir. 1976); United States v. Harper, 450 F.2d 1032, 1035 (5th Cir. 1971); Ramer v. United States, 411 F.2d 30, 38 (9th Cir.) cert. denied 396 U.S. 965 (1969).
- 137 See Harper, 450 F.2d at 1035; Ramer, 411 F.2d at 39.
- 138 In Re Zuniga, 714 F.2d at 638 (quoting Report No. 45, Group for the Advancement of Psychiatry 92 [1960]); Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955) (quoting M. Guttmacher and H. Weihofen, Psychiatry and Law [1952]); Ex Rel Edney, 425 F. Supp. at 1043; Calloway v. Marvel Entertainment Group, 110 F.R.D. 45, 49 (1986).
- 139 In Re Search Warrant (Sealed), 810 F.2d 67, 71 (3d Cir. 1987); In Re Doe, 711 F.2d at 1193; United States v. Lindstrom, 698 F.2d at 1167; United States v. Friedman, 636 F. Supp. 462 (S.D.N.Y. 1986).
- 140 Supra notes 24-48.
- 141 In Re Zuniga, 714 F.2d at 636; Jennings v. D.H.L. Airlines, 101 F.R.D. 549, 550 (N.D. Ill. 1984); Flora v. Hamilton, 81 F.R.D. 576, 578 (M.D.N.C. 1978); Lora v. Board of Education, 74 F.R.D. 565, 584-587 (E.D.N.Y. 1977); see also Meagher, 531 F.2d at 753 (although not recognizing a psychotherapist-patient

privilege, the court still looked to Proposed Rule 504 for its analysis).

142 714 F.2d 632 (6th Cir.) cert. denied, 464 U.S. 983 (1983).

143 Id. at 639.

144 Id. at 634.

145 Id.

146 Id. at 640, 642.

147 Id. at 636-639; cf. Note, Evidence-The

Psychotherapist-Patient Privilege. The Sixth Circuit Does The Decent Thing: In Re Zuniga, 33 U. Kan L. Rev. 385 n.81 (1985) (the court failed to anticipate arguments that Proposed Rule 504 is irrelevant since Congress rejected it) [hereinafter cited as Sixth Circuit Does the Decent Thing].

148 Id. at 637 (quoting Trammel v. United States, 445 U.S. 40, 48 [1980]).

149 Id.

150 714 F.2d at 638-639.

151 Appendix A, infra.

152 Zuniga at 639 (quoting United States v. Gillock, 445 U.S. 360, 369 n.8 [1980]).

153 Supra note 28 and accompanying text.

154 Id.

155 Zuniga at 639 (quoting Report No. 45, Group for the Advancement of Psychiatry 92 [1960] in 56 F.R.D. AT 242).

156 Id. at 639.

157 Id.

158 Id.

159 Supra note 28 and accompanying text.

160 Id. at 640.

161 Id.; In Re Pebsworth, 705 F.2d 261, 262 (7th Cir. 1983).

162 Id. at 640.

163 Cf. Sixth Circuit Does the Decent Thing, supra note 145, at 396-397 (stating that the Zuniga court only addressed a few of Wigmore's queries, but the article fails to state which ones).

164 Zuniga at 641.

165 Id. at 641-642 (citing Whalen v. Roe, 429 U.S. 589, 603-607
[1976]).

166 Id.

167 Id. at 642, n.11.

168 531 F.2d 752 (5th Cir.) cert. denied 429 U.S. 853 (1976).

169 Id. at 753.

170 Id.; see Proposed Rule 504(d)(3), 56 F.R.D. at 241.

171 Lora v. Board of Ed. of City of New York, 74 F.R.D. 565,
584 (E.D.N.Y. 1977).

172 Id. at 569; Flora v. Hamilton, 81 F.R.D. 576, 578 (M.D.N.C.
1978).

173 Zuniga, 714 F.2d at 637-638 (citing United States v. Nixon,
418 U.S. at 711).

174 711 F.2d 1187, 1193 (2d Cir.1983).

175 Id. (arguably these conditions could obtain in a true
psychotherapist-patient relationship); see In Re Grand Jury
Subpoenas Duces Tecum, 638 F. Supp. 794, 796 (D.Me 1986).

176 636 F. Supp. 462 (S.D.N.Y. 1986).

177 Id. at 463.

178 Id.

179 Roe v. Wade, 410 U.S. 113, 152 (1972).

180 Whalen v. Roe, 429 U.S. 589, 599-600 (1976).

181 410 U.S. at 153.

182 410 U.S. 179, 197; see also 410 U.S. at 219-220 (Douglas, J.,
concurring) ("This [statute] is a total destruction of the right of
privacy between physician and patient and the intimacy of relation
which that entails.").

183 Id. at 197; see also Roe v. Ingraham, 403 F.Supp. 931, 936
(S.D.N.Y. 1975) rev'd sub nom, Whalen v. Roe, 429 U.S. 589
(1976) (extending the right of privacy to the doctor-patient
relationship in accordance with the trial court's reading of Roe v.
Doe).

184 413 U.S. 49, 66 n.13 (1972).

185 Hawaii Psychiatric Soc., Dist. Branch v. Ariyoshi, 481
F.Supp. 1028, 1039 (D. Hawaii 1979).

186 Roe v. Ingraham, 403 F.Supp. at 937; Ex Rel. Edney, 425 F.Supp. 1042-1043; contra. Felber v. Foote, 321 F.Supp. 85, 88 (D.Conn. 1970).

187 Ex Rel. Edney, at 1043.

188 Id. at 1043-1044.

189 See Caesar v. Mountanos, 542 F.2d 1064, 1067 n.9 (9th Cir. 1976); United States v. Layton, 90 F.R.D. 520, 526 (N.D.Cal. 1981); cf. Krattenmacher, supra note 3, at 90 ("Claims that the Constitution compels recognition ... of a doctor-patient privilege cannot be dismissed cavalierly.").

190 Roe v. Wade, 410 U.S. at 154; see also Carey v. Population Services International, 431 U.S. 678, 686 (1976); Whalen, 429 U.S. at 603-604.

191 Roe v. Wade, 410 U.S. at 155; Carey, 431 U.S. at 686.

192 Roe, 410 U.S. at 155.

193 Id. at 163.

194 698 F.2d 1154, 1167 (11th Cir. 1983).

195 Contra, United States v. Brown, 479 F.Supp. 1247, 1253-1257 (D.Md. 1979) (denying defendant access to witness' psychiatric records to aid in cross-examination because it was irrelevant and an unwarranted invasion of the witness' privacy).

196 Hawaii Psychiatric Soc., 481 F.Supp. at 1041-1042.

197 United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (3rd Cir. 1980).

198 Id. at 570.

199 Id. at 577.

200 410 U.S. at 589.

201 Westinghouse, 638 F.2d at 577 ("Information about one's body and state of health is matter which the individual is ordinarily entitled to retain within the private enclave where he may lead a private live.").

202 Id. at 578 (citing Whalen, 429 U.S. at 602 n.29).

203 Id.; In Re Search Warrant (Sealed), 810 F.2d 67, 72 (3d Cir. 1987).

204 Westinghouse, 638 F.2d at 580; see In Re Search Warrant, 810 F.2d at 73 (physician's medical records could be seized pursuant

to a search warrant during a criminal investigation into possible insurance fraud).

205 Mil. R. Evid. 501(a)(4).

206 Saltzburg, Evidence supra note 6, at 417.

207 Supra note 88 and accompanying text.

208 42 U.S.C.A. sec. 242a(a) (West 1982).

209 Id.

210 42 U.S.C.A. sec. 290ee-3 (West Supp. 1987); see also 42 U.S.C.A. sec. 260(d) (West 1982) (precluding from use in any court the records of admission and treatment of anyone with a drug problem who voluntarily applies to the Surgeon General and is accepted for treatment in any United States Public Health Service Hospital).

211 Dep't of Army, Reg. No. 600-85, Alcohol and Drug Abuse Prevention and Control Program, para. 6-3 (3 November 1986) [hereinafter cited as AR 600-85] (Limited Use Policy).

212 Protection and Advocacy for Mentally Ill Individuals Act of 1986, Pub. L. No. 99-319, 100 Stat. 478 (1986).

213 Id., sec. 201, 100 Stat. at 485.

214 Id., sec. 201(1)(H), 100 Stat. at 486.

215 Id., sec. 201 (2)(B), 100 Stat. at 487.

216 United States v. Howes, 22 M.J. 704, 707 n.5 (A.C.M.R. 1986).

217 8 Wigmore, supra note 2, sec. 2380 at 819.

218 Appendix A (Alabama, Connecticut, Florida, Kentucky, Maryland, Massachusetts, New Mexico, South Carolina, Tennessee, and West Virginia have no physician-patient privilege).

219 Id. (only South Carolina and West Virginia have no such privilege); Zuniga, 714 F.2d at 638-639.

220 Shuman, supra note 35, at 907-913; Developments, supra note 3, at 1532, 1539-1542; Weinstein, Evidence, supra note 2, sec. 504(08) at 504-31 to 504-44.

221 Appendix A (those states include Alaska, Arizona, California, Montana, Pennsylvania, and Utah).

222 See, e.g., Ala. Code Sec. 34-26-2 (1985); Ariz. Rev. Stat. Ann. sec. 32-2085 (West 1986); Ga. Code Ann. sec. 24-9-21

(1982); Ga. Code Ann. sec. 43-39-16 (Supp. 1986); Iowa Code Ann. sec. 622.10 (West Supp. 1987); Kan. Stat. Ann. sec. 74-5323 (Supp. 1987); N.H. Rev. Stat. Ann. sec. 330:A:19 (Supp. 1986); N.Y. Civ. Prac. Law sec. 4507 (McKinney Supp. 1988); Pa. Cons. Stat. Ann. sec. 5944 (Purdon 1982); Tenn. Code Ann. sec. 63-11-213 (1986); Utah Code Ann. sec. 58-25-8 (1986); Wash. Rev. Code Ann. sec. 18.83.110 (1978).

²²³ See, e.g., N.H. Rev. Stat. Ann. sec. 329:26 (Supp. 1986); Wyo. Stat. sec. 1-12-101(a)(i) (1987).

²²⁴ 8 Wigmore, supra note 2, sec. 2290 and 2291 at 542, 545.

²²⁵ Weinstein, Evidence supra note 2, sec. 504(08) at 504-31; see also Federal Rules of Evidence for United States Courts and Magistrates [including] Uniform Rules of Evidence, 255-299 (West 1979) [hereinafter cited as Uniform Rules] (the Uniform Rules of Evidence were approved by the National Conference of Commissioners on Uniform State Laws in August 1974).

²²⁶ Id. at 504-32, 33.

²²⁷ See e.g., Alaska R. Evid. 504 (1979 & 1988 amend.); Ark. Stat. Ann. sec. 16-41-101, Unif. R. Evid. 503 (1987); Del. Unif. R. Evid. 503 (1987); Fla. Stat. Ann. sec. 90.503 (West 1979); Hawaii R. Evid. 504 (1985); Me. R. Evid. 503 (1987); Nev. Rev. Stat. sec. 49.215 & .225 (1986); N. M. R. Evid. 504 (1986); N. D. R. Evid. 504 (Supp. 1987); Okla. Stat. Ann. tit. 12, sec. 2503 (West Supp. 1988); Vt. R. Evid. 503 (1983 & Supp. 1987).

²²⁸ 56 F.R.D. at 244 (Advisory Committee's Note to Proposed Rule 504).

²²⁹ See supra note 101.

²³⁰ Id.

²³¹ Ala. Code sec. 26-14-3 (1986); Alaska Stat. sec. 47.17.020 (1984); Ariz. Rev. Stat. Ann. sec. 13-3621 (West Supp. 1987); Ark. Code Ann. sec. 12-12-504 (1987); Cal. Penal Code sec. 11166.5 (West Supp. 1988); Colo. Rev. Stat. sec. 19-10-104 (1986); Conn. Gen. Stat. Ann. sec. 17-38a (West Supp. 1987); Del. Code Ann. tit. 16, sec. 903 (1983); D. C. Code Ann. sec. 2-1352 (1981); Fla. Stat. Ann. sec. 4125.512 (Supp. 1987); Ga. Code Ann. sec. 19-7-5 (1982); Hawaii Rev. Stat. sec. 350-1.1

(Supp. 1987); Idaho Code sec. 16-1619 (Supp. 1987); Ill. Rev. Stat. ch. 23, para. 2054 (Smith-Hurd 1987); Ind. Code sec. 35-46-1-13 (1985); Iowa Code Ann. sec. 232.69 (West Supp. 1987); Kan. Stat. Ann. sec. 39-1402 (1986); Ky. Rev. Stat. sec. 199.335 (Michie/Bobbs-Merrill Supp. 1986); La. Rev. Stat. Ann. sec. 14-403 (West 1986); Me. Rev. Stat. Ann. tit. 22, sec. 4011 (Supp. 1987); Md. Fam. Law Code Ann. sec. 5-903 (1984); Mass. Gen. Laws Ann. ch. 119, sec. 51A (West Supp. 1987); Mich. Comp. Laws Ann. sec. 722.623 (West Supp. 1987); Minn. Stat. Ann. sec. 626.556 (West Supp. 1988); Miss. Code Ann. sec. 43-21-353 (Supp. 1987); Mo. Ann. Stat. sec. 210.115 (Vernon 1983); Mont. Code Ann. sec. 41-3-201 (1987); Neb. Rev. Stat. sec. 28-711 (1985); Nev. Rev. Stat. sec. 432B.220 (Supp. 1987); N. H. Rev. Stat. Ann. sec. 169-C: 29 (Supp. 1986); N. J. Stat. Ann. sec. 9:6-8.10 (West 1986); N. M. Stat. Ann. sec. 32-1-15 (1986); N. Y. Soc. Svcs. Law sec. 413 (McKinney Supp. 1988); N. C. Gen. Stat. sec. 7A-543 (1986); N. D. Cent. Code sec. 50-25.1-03 (Supp. 1987); Ohio Rev. Code Ann. sec. 2151.42.1 (Page Supp. 1987); Okla. Stat. Ann. tit. 21, sec. 846 (West Supp. 1988); Or. Rev. Stat. sec. 418.750 (1983); 11 Pa. Cons. Stat. Ann. sec. 2204 (Purdon Supp. 1987); R. I. Gen. Laws sec. 40-11-3 (Supp. 1987); S. C. Code Ann. sc. 20-7-510 (Law Co-op. 1985); S.D. Codified Laws Ann. sec. 26-10-10 (Supp. 1987); Tenn. Code Ann. sec. 37-1-403 (Supp. 1987); Tex. Fam. Code Ann. art. 34.01 (Vernon Supp. 1988); Utah Code Ann. sec. 78-3b-3 (1987); Vt. Stat. Ann. tit. 33, sec. 683 (Supp. 1987); Va. Code Ann. sec. 63.1-248.3 (1987); Wash. Rev. Code Ann. sec. 26.44.030 (Supp. 1987); W. Va. Code Ann. sec. 49-6A-2 (1986); Wis. Stat. Ann. sec. 48.981(2) (1987); Wyo. Stat. sec. 14-3-205 (1987).

²³² See, e.g., Ariz. Rev. Stat. Ann. sec. 46-453 (West Supp. 1987); Cal. Evid. Code sec. 15637 (West Supp. 1988); Colo. Rev. Stat. sec. 19-10-112 (1986); Fla. Stat. Ann. sec. 425.512 (Supp. 1987); Hawaii Rev. Stat. sec. 350-5 (Supp. 1987); Idaho R. Evid. 503 (1987); Ind. Code sec. 34-1-14-5 (1986); Iowa Code Ann. sec. 232.74 (West 1985); Minn. Stat. Ann. sec. 595.02(2) (West

Supp. 1988); Mont. Code Ann. sec. 41-3-201 (1987); N. C. Gen. Stat. sec. 8-53.1 (Supp. 1987); Tex. Fam. Code Ann. art. 34:04 (Vernon 1986); Utah Code Ann. sec. 78-3b-13(4) (1987); see also Developments, supra note 3, at 1539.

²³³ See, e.g., Cal. Evid. Code sec. 1024 (West 1966); Conn. Gen. Stat. Ann. sec. 52-146f (West Supp. 1987); Fla. Stat. Ann. sec. 491.0187 (Supp. 1987); Mass. Gen. Laws Ann. ch. 233, sec. 20B (West 1986 & Supp. 1987); Minn. Stat. Ann. sec. 148.975 (West Supp. 1988).

²³⁴ See Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (Supreme Court of California held that therapists have a duty to exercise reasonable care in protecting persons threatened by their patients); Developments, supra note 3, at 1541.

²³⁵ See, e.g., Minn. Stat. Ann. sec. 625.52 (West Supp. 1988).

²³⁶ See, e.g., D. C. Code Ann. sec. 14-307 (1981 & Supp. 1987); Ill. Rev. Stat. ch. 110, para. 8-802 (Smith-Hurd Supp. 1987); Ind. Code sec. 25-33-1-17 (Supp. 1987); Wis. R. Evid. 905.04 (1987).

²³⁷ See, e.g., Ariz. Rev. Stat. Ann. sec. 46-453 (West Supp. 1987); Fla. Stat. Ann. sec. 415.109 (West Supp. 1987); Kan. Stat. Ann. sec. 39-1402 (1986); Mass. Gen. Laws Ann. ch. 19A, sec. 15 (West Supp. 1987); Minn. Stat. Ann. sec. 626.557 (West Supp. 1988); Mont. Code Ann. sec. 53-5-511 (1987).

²³⁸ See, e.g., Conn. Gen. Stat. Ann. 19a-458a (West Supp. 1987); Neb. Rev. Stat. sec. 27-504 (1985).

²³⁹ N. C. Gen. Stat. sec. 8-53.3 (Supp. 1987); Va. Code Ann. sec. 8.01-399 (1984).

²⁴⁰ See, e.g., United States v. Toledo, 25 M.J. at 275.

²⁴¹ These include the three exceptions to Proposed Rule 504, supra note 101, and confidential communications concerning child abuse.

²⁴² See generally Mil. R. Evid. 505 (Classified information is privileged from disclosure if disclosure would be detrimental to the national security).

²⁴³ See, e.g., Manual for Courts-Martial, United States, 1917 (Rev. ed.), para. 231-232 (Communications from officers and soldiers and medical officers not privileged; Communications between civilian physicians and patients not privileged); Manual for Courts-Martial, United States, 1928 (Rev. ed.), para. 123c (Communications to medical officers and civilian physicians not privileged); Manual for Courts-Martial, United States, 1951, para. 151c(2) (Communications to medical officers and civilian physicians not privileged); Manual for Courts-Martial, United States, 1969 (Rev. ed.), para. 151(c)(2) (same provision as in the 1951 Manual with minor grammatical changes); MCM, 1984, Mil. R. Evid. 501(d) (text is located supra note 7).

²⁴⁴ Mil. R. Evid. 501 analysis.

²⁴⁵ Winthrop, supra note 7 at 331-332; United v. Shaw, 9 C.M.A. 267, 269 26 C.M.R. 47, 49 (1958) (when the defense asserted that a navy psychiatrist was precluded from testifying pursuant to a psychiatrist-patient privilege, the Court of Military Appeals stated that the privilege does not exist absent a statute).

²⁴⁶ Mil. R. Evid. 501 analysis.

²⁴⁷ Id., see also United States v. Johnson, 47 C.M.R. 402, 406 (C.M.A. 1973) (the question of privilege is governed by the law of the forum).

²⁴⁸ Mil. R. Evid. 302 analysis.

²⁴⁹ Funk v. United States, 290 U.S. 371, 381 (1933) (common law rule preventing a spouse from testifying on behalf of other spouse in a criminal case was struck down); cf. United States v. Leach, 7 C.M.A. 388, 22 C.M.R. 178 (1956).

²⁵⁰ Saltzburg, Evidence, supra note 6, at 417.

²⁵¹ See United States v. Parker, 15 M.J. 146 (C.M.A. 1983); United States v. Johnson, 47 C.M.R. at 406; United States v. Shaw, 9 C.M.A. 267, 26 C.M.R. 47 (1958).

²⁵² See e.g., United States v. Welch, 25 M.J. 23 (C.M.A. 1987) (statements made to psychologists are admissible under Mil. R. Evid. 803[4]); United States v. White, 25 M.J. 50 (C.M.A. 1987).

²⁵³ United States v. Fields, 3 M.J. 27, 29 (C.M.A. 1977); United States v. Moore, 15 M.J. 354, 360-361 (C.M.A. 1983); cf. Mil. R.

Evid. 702, enacted after these two cases, provides a much lower threshold for qualification as an expert.

²⁵⁴ R.C.M. 706(c)(1) (changed by C3, 3 March 1987).

²⁵⁵ MCM, United States, 1984, Rules for Courts-Martial 706 analysis (C3, 3 March 1987) (1986 Amendment modified the rule to mirror the similar use of clinical psychologists under federal law) [hereinafter cited as R.C.M. 706 analysis].

²⁵⁶ Id.

²⁵⁷ See generally United States v. Moore, 15 M.J. at 360 ("American judicial opinion is divided on the qualifications of a psychologist, as distinguished from a psychiatrist, to testify to the mental or emotional state of an individual and the impact of the particular state on the individual's behavior.") (citing United States v. Fields, 3 M.J. 27 [C.M.A. 1977]).

²⁵⁸ See, e.g., United States v. Parker, 15 M.J. 146 (C.M.A. 1983); United States v. Johnson, 47 C.M.R. 402 (C.M.A. 1973).

²⁵⁹ See, e.g., United States v. Toledo, 25 M.J. 270 (C.M.A. 1987); United States v. Wimberley, 16 C.M.A. 3, 36 C.M.R. 159 (C.M.A. 1966); United States v. Shaw, 9 C.M.A. 267, 26 C.M.R. 47 (1958).

²⁶⁰ See, e.g., United States v. White, 25 M.J. 50 (C.M.A. 1987); United States v. Reece, 25 M.J. 93 (C.M.A. 1987); United States v. Wimberley, 16 C.M.A. 3, 36 C.M.R. 159 (1966); United States v. Shaw, 9 C.M.A. 267, 26 C.M.R. 47 (1958).

²⁶¹ See Mil. R. Evid. 302(a); R.C.M. 706 (c)(5).

²⁶² See United States v. Babbidge, 18 C.M.A. 327, 40 C.M.R. 39 (1969).

²⁶³ Mil. R. Evid. 302 analysis; see also United States v. Johnson, 47 C.M.R. at 406.

²⁶⁴ United States v. Shaw, 9 C.M.A. at 270, 26 C.M.R. at 50.

²⁶⁵ See, e.g., United States v. Toledo, 25 M.J. at 275.

²⁶⁶ Cf. AR 600-85, supra note 209, para. 6-3 to 6-5 (ADAPCP communications and records may be protected if the treatment was conducted in accordance with the regulation's guidelines).

- 267 Uniform Code of Military Justice, art. 36, 10 U.S.C. sec. 836(a) (1987) [hereinafter cited as UCMJ] (the UCMJ, as originally passed in 1950, 64 Stat. 107, included 140 articles).
- 268 Woodruff, Privileges Under the Military Rules of Evidence, 92 Mil. L. Rev. 7 (1981) [hereinafter cited as Privileges Under the MRE's].
- 269 Supra note 98.
- 270 Mil. R. Evid. 501 analysis.
- 271 Mil. R. Evid. 501.
- 272 Mil. R. Evid. 502; Proposed Federal Rule 503, 56 F.R.D. at 235-237.
- 273 Mil. R. Evid. 503; Proposed Federal Rule 506, 56 F.R.D. at 247-249.
- 274 Mil. R. Evid. 504; Proposed Federal Rule 505, 56 F.R.D. 244-247.
- 275 Mil. R. Evid. 507; Proposed Federal Rule 510, 56 F.R.D. at 255-258.
- 276 Mil. R. Evid. 508; Proposed Federal Rule 507, 56 F.R.D. at 249; see Privileges Under the MRE's, supra note 268, at 7-8.
- 277 Mil. R. Evid. 501 analysis.
- 278 United States v. Parker, 15 M.J. 146 (C.M.A. 1983); United States v. Wimberley, 16 C.M.A. at 12, 36 C.M.R. at 168.
- 279 Mil. R. Evid. 501 analysis; United States v. Tipton, 23 M.J. 338 (C.M.A. 1987); see United States v. Martel, 19 M.J. 917 (A.C.M.R. 1985).
- 280 United States v. Tipton, 23 M.J. at 343 (Rule 504 was intended to give specific guidance which requires a much simpler inquiry than in a federal criminal trial).
- 281 Mil. R. Evid. 501 provides:
- (a) A person may not claim a privilege with respect to any matter except as required by or provided for in:
- (1) The Constitution of the United States as applied to members of the armed forces;
 - (2) An Act of Congress applicable to trials by courts-martial;
 - (3) These rules or this Manual; or

(4) The principles of common law generally recognized in the trial of criminal cases in the United States district courts pursuant to Rule 501 of the Federal Rules of Evidence insofar as the application of such principles in trials by courts-martial is practicable and not contrary to or inconsistent with the Uniform Code of Military Justice, these rules, or this Manual.

(b) A claim of privilege includes, but is not limited to, the assertion by any person of a privilege to:

- (1) Refuse to be a witness;
- (2) Refuse to disclose any matter;
- (3) Refuse to produce any object or writing; or
- (4) Prevent another from being a witness or disclosing any matter or producing any object or writing.

(c) The term "person" includes an appropriate representative of the federal government, a State, or political subdivision thereof, or any other entity claiming to be the holder of a privilege.

(d) Notwithstanding any other provision of these rules, information not otherwise privileged does not become privileged on the basis that it was acquired by a medical officer or civilian physician in a professional capacity.

282 Id.

283 Id.

284 19 M.J. 917 (A.C.M.R. 1985).

285 Id.

286 Id. at 924-925; Mil. R. Evid. 504.

287 Martel, 19 M.J. at 925.

288 Id. at 926.

289 See also United States v. Johnson, 3 M.J. 143, 146 n.3

(C.M.A. 1977) (statement-against-penal-interest, though not a principle exception to the military hearsay rule, is an exception under certain circumstances to the Federal Rules of Evidence and, since it is not incompatible with military practice, it is a fully

applicable rule of evidence in military courts-martial); Privileges Under the MRE's, supra note 268 at 7.

290 Martel, 19 M.J. at 925.

291 Supra note 281.

292 Saltzburg, Evidence, supra note 6, at 417.

293 MCM, 1984, Rule 302.

294 Id.

295 Id.

296 Id.

297 United States v. Johnson, 47 C.M.R. 402 (C.M.A. 1973).

298 MCM, 1969 (Rev. ed.), para. 121; United States v.

Babbidge, 18 C.M.A. 327, 40 C.M.R. 39 (1969).

299 R.C.M. 706(c)(5).

300 See Rule 501 analysis.

301 Supra note 229 and accompanying text.

302 Saltzburg, Evidence, supra note 6, at 115.

303 United States v. Toledo, 25 M.J. at 275.

304 United States v. Bryant, 16 C.M.R. 747, 752 (A.B.R. 1954)

("The basis for the attorney-client privilege and the requirement of attorney fidelity are rooted deep in Anglo-American law. They parallel similar privileges implicit in relationships such as husband-wife, priest-penitent,... and physician-patient where pertinent.")

305 MCM, 1984, Rule 502 analysis.

306 Id.; Privileges Under the MRE's, supra note 268, at 15.

307 MCM, 1984, Rule 511; Privileges Under the MRE's, supra note 268, at 18.

308 MCM, 1984, Mil. R. Evid. 502; 8 Wigmore, supra note 2, sec. 2290 at 542.

309 Toledo, 25 M.J. at 275-276; Saltzburg, Evidence, supra note 6, at 426.

310 Toledo, 25 M.J. at 276.

311 Privileges Under the MRE's, supra note 268, at 13.

312 See, e.g., The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, sec. 9, 130 Am. J.

Psychiatry, 1058, 1059 (1973) ("The physician may not reveal the

confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of his patients, unless he is required to do so by law....") [hereinafter cited as APA Ethical code]; Ethical Principles of Psychologists, 36 Am. Psychologist 633, 635-636 (1981) (Principle 6 describes the primary obligation to maintain confidentiality of patient information, but makes no allowance for legally compelled disclosures).

313 Winthrop, supra note 7, at 331-332; United States v. Moreno, 20 M.J. 623, 625 (A.C.M.R. 1985).

314 MCM, 1951, para. 151b(2).

315 MCM, 1984, Mil. R. Evid. 503(a).

316 Id. at analysis.

317 Saltzburg, Evidence, supra note 6, at 434; MCM, 1984, Mil. R. Evid. 511.

318 United States v. Kidd, 20 C.M.R. 713, 719 (A.B.R. 1955).

319 MCM, 1984, Mil. R. Evid. 503.

320 8 Wigmore, supra note 2, sec. 2333, at 644.

321 MCM, 1984, Mil. R. Evid. 504 analysis.

322 Id.; see Trammel v. United States, 445 U.S. 40 (1980).

323 United States v. Trudeau, 8 C.M.A. 22, 23 C.M.R. 246 (1957).

324 15 C.M.A. 274, 35 C.M.R. 246 (1965).

325 MCM, 1969 (Rev. ed.), para. 148e; United States v. Menchaca, 47 C.M.R. 709 (A.C.M.R. 1973).

326 Funk v. United States, 290 U.S. 371 (1933).

327 See, e.g., Zuniga, 714 F.2d at 636-639.

328 United States v. Menchaca, 47 C.M.R. at 713.

329 United States v. Tipton, 23 M.J. 338 (C.M.A. 1987).

330 20 M.J. 623, 625-626 (A.C.M.R. 1985).

331 25 M.J. 93, 95 n.6 (1987).

332 Supra notes 207-216 and accompanying text.

333 Id.

334 United States v. Howes, 22 M.J. 704, 706 (A.C.M.R. 1986); supra note 210 and accompanying text.

335 Howes, 22 M.J. at 707.

336 Id.
337 Supra note 210 and accompanying text.
338 AR 600-85, para. 1-6a.
339 Id.
340 Id., para. 1-8; cf. Dep't of Army, Reg. No. 40-66, Medical
Record and Quality Assurance Administration, para. 2-7 (1 April
1987) (no information on the treatment, identity, prognosis, or
diagnosis for alcohol or drug abuse patients will be released
except per AR 600-85).
341 Id., para. 6-3.
342 Id., para. 6-4a.
343 Id.
344 Id.
345 Id., para. 6-4b.
346 Id.
347 Id., para. 6-1; see United States v. Howes, 22 M.J. at 707.
348 AR 600-85, para. 6-7a.
349 Id., para. 6-9.
350 22 M.J. 704, 705 (A.C.M.R. 1986) (The evidence indicated
that the accused had been previously enrolled in ADAPCP, and
subsequently rehabilitated for drug abuse); cf. United States v.
Bready, 12 M.J. 963 (A.F.C.M.R. 1982) (narrowly interpreting
an Air Force regulation that purported to allow admissibility of
statements made by soldiers regarding drug use incident to
military medical health care).
351 Howes, 22 M.J. at 706.
352 Id. at 707-708 n.5.
353 Id.; compare AR 600-85, supra note 211, para. 6-9 with 42
U.S.C.A. sec. 290ee-3(a).
354 Id. at 707-708 n.5.
355 See supra note 101 (definitions of psychotherapist includes a
person who engages in the diagnosis and treatment of a mental or
emotional condition, including drug addiction).
356 Howes, 22 M.J. at 704.
357 Toledo, 25 M.J. at 275.
358 Id.

359 See Mil. R. Evid. 302.
360 Supra notes 258-266 and accompanying text.
361 MCM, 1984, Mil. R. Evid. 302.
362 See MCM, 1984, Mil. R. Evid. 501(d) analysis.
363 25 M.J. at 275-276.
364 Id. at 271.
365 Id. at 274.
366 Id.
367 Id.
368 Id. at 270.
369 Id.
370 Id. at 275.
371 Id.
372 Id.
373 Id.; Mil. R. Evid. 502(a).
374 Toledo, 25 M.J. at 276.
375 Id.
376 Id.
377 Id.
378 see Wittman, United States v. Toledo-A Quasi
Psychiatrist-Patient Privilege (1988).
379 See, e.g., Zuniga, 714 F.2d at 638.
380 See Appendix A, infra.
381 A civilian can be tried in a court-martial if he commits
offenses during time of war while serving with or accompanying
the armed forces in the field. UCMJ, art. 2(a)(10).
382 See, e.g., United States v. Eshalomi, 23 M.J. 12 (C.M.A.
1986) (psychiatric reports on victim should have been disclosed to
the defense).
383 See e.g., United States v. Reece, 25 M.J. 93 (C.M.A. 1987)
(state law mandating confidentiality of juvenile alcohol and drug
treatment records did not prevent trial judge from ordering
disclosure if he so ordered).
384 See Mil. R. Evid. 501(d).
385 Supra note 231.
386 See Appendix B, question 8, infra.

387 MCM, 1984, Mil. R. Evid. 501 analysis.

388 Supra note 312.

389 See Appendix B, question 12, infra.

390 See, e.g., supra note 386 and accompanying text.

391 See, e.g., United States v. Wright, 8 C.M.R. 850, 852 (A.F.B.R. 1953).

392 See, e.g., APA ethical code, supra note 386.

393 J. Klein, J. Macbeth, and J. Onek, Legal Issues in the Private Practice of Psychiatry, 39 (1984) [hereinafter cited as Klein]].

394 Id. at 40.

395 Feres v. United States, 340 U.S. 135 (1950).

396 Cutter v. Brownridge, 283 Cal. App. 3d 836, 228 Cal. Rptr. 545 (1986).

397 Klein, supra note 393, at 42.

398 The Psychotherapist-Patient Privilege in Washington: Extending the Privilege to Community Mental Health Clinics, 58 Wash. L. Rev. 565, 572 (1983) (citing Professor Robert Aronson, Professor of evidence at the University of Washington as the source of the term) [hereinafter cited as Privilege in Washington].

399 Id.

400 Id.; see Appendix B, question no. 14 (Survey responses reflected various examples of this conduct).

401 Shuman, supra note 35; see also Comment, Functional Overlap Between The Lawyer and Other Professionals, 71 Yale L. J. 1226 (1962) (questionnaire study of psychotherapists, psychologists, marriage counselors, lawyers, judges and lay people concerning privileges) [hereinafter cited as Functional Overlap]; Note, Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff, 31 Stan. L. Rev. 164 (1978) (empirical survey of California therapists to ascertain the effects of a State Supreme Court case requiring psychotherapists to warn of patients dangerous to themselves or others) [hereinafter cited as Public Peril].

402 Shuman, supra note 35 at 893.

403 Id.
404 Id.
405 Appendix A, infra.
406 Shuman, supra note 35, at 921.
407 Id.; see Functional Overlap, supra note 401, at 1256 nn. 192
& 196 (only three of thirty-five psychiatrists and six of fifty-one
psychologist had been asked in court to disclose confidential
information).
408 Shuman, supra note 35, at 935 (Table 3, Appendix, question
5c).
409 Id. at 921.
410 Id.; see Public Peril, supra note 401, at 177 n.66 (of 179
psychologist and 1093 psychiatrist surveyed, 14.5% discussed
confidentiality with patients as a general practice, 63.7% discussed
it if it came up in therapy, 8.9% discussed it only if asked, and
13% did not respond).
411 Shuman, supra note 35, at 921.
412 Id.
413 Id.
414 Id. at 927.
415 Id.
416 Id.; contra, Public Peril, supra note 401, at 176 n.63 (of 179
psychologist and 1093 psychiatrist surveyed, 79% believed, in
their opinion, that patients would feel inhibited if they knew that
their communications were not governed by strict confidentiality).
417 Appendix B, infra.
418 Shuman, supra note 35, at 934 (Table 3, Appendix).
419 Id. at question 1.
420 Id. at questions 2 & 3.
421 Id. at question 4.
422 Id. at question 5 (only includes the respondents residing in
the continental United States, Hawaii, and Alaska).
423 Supra note 231.
424 Appendix B, infra at question 6.
425 Id. at question 19; see Dep't of Defense Directive No. 6400.1,
Family Advocacy Program, para. F.1 (10 July 1986).

426 Appendix B, infra at question 17.
427 Id. at question 18.
428 Id. at question 7.
429 Id. at question 8.
430 Id.
431 Id. at question 9.
432 Id. at question 10.
433 Id.
434 Id. at question 11.
435 Id.
436 Id.
437 Id.
438 Id.
439 Id. at question 12.
440 Id. at question 13.
441 Id. at question 14.
442 Id.
443 Survey responses Nos. 28, 40.
444 Survey responses Nos. 5, 17.
445 Survey responses Nos. 6, 30, 37.
446 Survey responses Nos. 40, 44, 57, 61.
447 Survey responses Nos. 7, 19, 20, 25, 27, 35, 48, 54.
448 Survey responses Nos. 1, 11, 42, 49, 54.
449 Survey responses Nos. 18, 21, 41, 42, 46.
450 Appendix B, infra at question 15.
451 Id. at question 16.
452 Supra note 91 and accompanying text.
453 See, e.g., Zuniga, 714 F.2d at 632.
454 Appendix A, infra (South Carolina and West Virginia).
455 Supra notes 254-257 and accompanying text.
456 Supra notes 339-354 and accompanying text.
457 Mil. R. Evid. 302.
458 Id.; see supra note 229 and accompanying text.
459 Mil. R. Evid. 502; 25 M.J. at 275.
460 Mil. R. Evid. 501(a).
461 Mil. R. Evid. 501 analysis.

462 Appendix C, infra.
463 Supra note 101.
464 Mil. R. Evid. 501 analysis.

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STATE PRIVILEGE LAW SUMMARY

<u>STATE</u>	<u>PHYSICIAN- PATIENT PRIVILEGE</u>	<u>PSYCHIATRIST- PATIENT PRIVILEGE</u>	<u>PSYCHOLOGIST- PATIENT PRIVILEGE</u>	<u>PSYCHOTHERAPIST- PATIENT PRIVILEGE</u>
Alabama	-	Civ.&Crim. Ala.Code sec. 34-26-2(1985)	Civ.&Crim. Ala.Code sec. 34-26-2(1985)	
Alaska	Civil only Alaska R. Evid. 504 (1979 & 1988 amend.)			Civ.&Crim. Alaska R. Evid. 504 (1979 & 1988 amend.)
Arizona	Civil only Ariz. Rev. Stat. Ann. 12-2235 (West 1982)			Civ.&Crim. Ariz. Rev. Stat. Ann. sec. 32-2085 (West 1986)
Arkansas	Civ.&Crim. Ark.Stat. Ann.sec.16- 41-101,Unif. R.Evid.503 (1987)			Civ.&Crim. Ark. Stat. Ann. sec. 16-41-101, Unif. R. Evid. 503 (1987)
California	Civil only Cal.Evid. Code sec. 994(West 1966 & Supp. 1988)			Civ.&Crim. Cal. Evid. Code sec.1014 (West 1966 & Supp. 1988)
Colorado	Civ.&Crim. Colo. Rev. Stat. sec. 13-90-107- (d)(1987)		Civ.&Crim. Colo. Rev. Stat. sec. 13-90-107(g) (1987)	
Connecticut		Civ.&Crim. Conn. Gen. Stat. Ann. sec.52-146 (d) (West Supp. 1987)	Civ.&Crim. Conn. Gen. Stat. Ann. sec.52-146(c) (West Supp. 1987)	
Delaware	Civ.&Crim. Del. Unif. R.Evid.503 (1987)			Civ.&Crim. Del. Unif. R. Evid. 503 (1987)

NOTE: State physician definitions included psychiatrists. State psychotherapists definitions varied, but included psychiatrists and licensed or certified psychologists at a minimum.

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District of Columbia	Civ.&Crim. D.C.Code Ann.sec.14 -307(1981& Supp.1987)		Civ.&Crim. D.C.Code Ann. sec.6-2002 (1981)	
Florida				Civ.&Crim. Fla. Stat. Ann. sec. 90.503 (West 1979)
Georgia	Civ.&Crim. Ga.Code Ann.sec. 24-9-40 (1982)		Civ.&Crim. Ga.Code Ann. 24-9-21 (1982)	Civ.&Crim. Ga.Code Ann. sec.43-39-16 (Supp. 1987)
Hawaii	Civ.&Crim. Hawaii Rev. Stat.sec. 626.1 Hawaii R. Evid.504 (1985)		Civ.&Crim. Hawaii Rev. Stat. sec. 626.1, Hawaii R. Evid.504.1 (1985)	
Idaho	Civ.&Crim. Idaho R. Evid. 503 (1987)			Civ.&Crim. Idaho R.Evid. 503(1987)
Illinois	Civ.&Crim. Ill. Rev. Stat.ch.110 para.8-802 (Smith-Hurd 1987)			Civ.&Crim. Ill. Ann.Stat. ch.111, para. 5306(Smith-Hurd Supp. 1987)
Indiana	Civ.&Crim. Ind. Code sec.34-1- 14-5(1986)			Civ.&Crim. Ind.Code sec. 25-33-1-17 Supp. 1987)
Iowa	Civ.&Crim. Iowa Code Ann. sec. 622.10 (West Supp. 1987)			Civ.&Crim. Iowa Code Ann. sec. 622.10 (West Supp. 1987)

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Kansas	Civ.&Crim. Kan. Stat. Ann. sec. 60-427 (1983)		Civ.&Crim. Kan.Stat.Ann. sec. 74-5323 (Supp. 1987)	
Kentucky		Civ.&Crim. Ky.Rev.Stat. sec. 421.215 (Michie/Bobbs -Merrill Supp.1986)	Civ.&Crim. Ky.Rev.Stat. sec. 319.111 (Michie/Bobbs Merrill Supp. 1986)	
Louisiana	Civ.&Crim. La.Rev.Stat. Ann.sec.15- 476(West 1981)		Civ.&Crim. La.Rev.Stat. Ann.sec.37- 2366(West 1974)	
Maine	Civ.&Crim. Me.R.Evid. 503(1987)			Civ.&Crim. Me. R. Evid. 503 (1987)
Maryland		Civ.&Crim. Md.Cts.&Judic. Proc.Ann.sec. 9-109(1984)	Civ.&Crim. Md.Cts.&Judic. Proc.Ann.sec. 9-109(1984)	
Massachusetts				Civ.&Crim. Mass.Gen.Laws Ann.ch.233, sec. 20B(West 1986 & Supp. 1987)
Michigan	Civ.&Crim. Mich.Comp. Laws Ann. sec.600. 2157(West 1986)	Civ.&Crim. Mich.Comp. Laws Ann.sec. 330.1750(West Supp. 1987)	Civ.&Crim. Mich.Comp.Laws Ann.sec.330. 1750(West Supp. 1987)	
Minnesota	Civ.&Crim. Minn.Stat. Ann.sec. 595.02(1) (d)(West Supp. 1988)		Civ.&Crim. Minn.Stat.Ann. sec.595.(1)(g) (West Supp. 1988)	

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Mississippi	Civ.&Crim. Miss.Code Ann.sec. 13- 1-21(Supp. 1987) & Miss.R.Evid 503(1987)		Civ.&Crim. Miss.Code Ann. sec. 73-31-29 (1973 & Supp. 1987) & Miss.R.Evid. 503(1987)	
Missouri	Civ.&Crim. Mo.Ann.Stat. sec. 491.060 (Vernon Supp. 1988)		Civ.&Crim. Mo.Ann.Stat. sec. 337.055 (Vernon Supp. 1988)	
Montana	Civ. Only Mont. Code Ann.sec.26- 1-805(1987)		Civ.&Crim. Mont.Code Ann. sec. 26-1-807 (1987)	
Nebraska	Civ.&Crim. Neb.Rev.Stat. sec. 27-504 (1985)		Civ.&Crim. Neb.Rev.Stat. sec. 27-504 (1985)	
Nevada	Civ.&Crim. Nev.Rev.Stat. sec. 49.215, .225(1986)		Civ.&Crim. Nev.Rev.Stat. sec. 49.215, .225(1986)	
New Hampshire	Civ.&Crim. N.H.Rev.Stat. Ann.sec.329: 26(Supp.1986) & N.H.R.Evid. 503(a)(1987)		Civ.&Crim. N.H.Rev.Stat. Ann.sec.330:A. 19(Supp.1986) & N.H.R.Evid. 503(b)(1987)	
New Jersey	Civ.&Crim. N.J.Stat.Ann. sec. 2A:84A- 22.2(West 1986)		Civ.&Crim. N.J.Stat.Ann. sec. 45:14B-28 (West Supp. 1987)	
New Mexico			Civ.&Crim. N.M.Stat.Ann. sec. 61-9-18 (1986) & N.M.R. Evid.504(1986)	Civ.&Crim. N.M.R.Evid. 504(1986)

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New York	Civ. Only N.Y.Civ. Prac. Law sec. 4504 (McKinney Supp. 1988)		Civ. Only N.Y.Civ.Prac. Law sec. 4507 (McKinney Supp. 1988)	
North Carolina	Civ.&Crim. N.C.Gen. Stat. sec. 8-53(1986)		Civ.&Crim. N.C.Gen.Stat. sec. 8-53.3 (Cumm. Supp. 1987)	
North Dakota	Civ.&Crim. N.D.R.Evid. 503(Supp. 1987)		Civ.&Crim. N.D.R.Evid. 503(Supp.1987)	
Ohio	Civ.&Crim. Ohio Rev. Code Ann. sec. 2317. 02(B)(Page Supp. 1987)		Civ.&Crim. Ohio Rev.Code Ann.sec.4732. 19(Page 1987)	
Oklahoma	Civ.&Crim. Okla.Stat. Ann.tit.12, sec. 2503 (West Supp. 1988)			Civ.&Crim. Okla.Stat.Ann. tit. 12,sec. 2503(West Supp. 1988)
Oregon	Civ.&Crim. Or.Rev.Stat. sec. 40.235 Rule 504-1 (1983)			Civ.&Crim. Or.Rev.Stat. sec. 40.230 Rule 504(1983)
Pennsylvania	Civ. Only 42 Pa.Cons. Stat.Ann. sec. 5929 (Purdon 1982)		Civ.&Crim. 42 Pa.Cons. Stat.Ann.sec. 5944(Purdon 1982)	
Rhode Island	Civ.&Crim. R.I.Gen.Laws sec.5-37/3-4 (1987)		Civ.&Crim. R.I.Gen.Laws sec. 5-37.3-4 (1987)	

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<u>STATE</u>	<u>PHYSICIAN- PATIENT PRIVILEGE</u>	<u>PSYCHIATRIST- PATIENT PRIVILEGE</u>	<u>PSYCHOLOGIST- PATIENT PRIVILEGE</u>	<u>PSYCHOTHERAPIST- PATIENT PRIVILEGE</u>
South Carolina	-			
South Dakota	Civ.&Crim. S.D.Codified Laws Ann. sec.19-13-6 to -11(1987)			Civ.&Crim. S.D.Codified Laws Ann. sec. 19-13-6 to-11(1987)
Tennessee		Civ.&Crim. Tenn.Code Ann. sec.24-1-207 (Supp. 1986)	Civ.&Crim. Tenn.Code Ann. sec.63-11-213 (1986)	
Texas	Civ. Only Tex.Rev.Civ. Stat.Ann. art.4495b, sec. 5.08 (Vernon Supp. 1988) & Tex.R.Civ. Evid.509 (1987)			Civ. Only Tex.Rev.Civ. Stat. art.5561h (Vernon Supp. 1988) & Tex. R. Civ. Evid. 510 (1987)
Utah	Civ. Only Utah Code Ann. sec. 78-24-8(4) (1987)		Civ.&Crim. Utah Code Ann. sec. 58-25-8 (1986)	
Vermont	Civ.&Crim. Vt.Stat.Ann. tit.12, sec. 1612(Supp. 1987)		Civ.&Crim. Vt.Stat.Ann. tit.12, sec. 1612(Supp. 1987)	
Virginia	Civ. Only Va.Code Ann.sec. 8.01-399 (1984)		Civ. Only Va.Code Ann. sec. 8.01-399 (1984)	
Washington	Civ.&Crim.* Wash.Rev. Code Ann. sec. 5.60. 060(4)(Supp. 1987)		Civ.&Crim. Wash.Rev.Code Ann.sec.18.83. 110(1978)	

*Extended to Criminal cases by State v. McKoy, 70 Wash. 2d 964, 425 P.2d 874 (1967).

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<u>STATE</u>	<u>PHYSICIAN- PATIENT PRIVILEGE</u>	<u>PSYCHIATRIST- PATIENT PRIVILEGE</u>	<u>PSYCHOLOGIST- PATIENT PRIVILEGE</u>	<u>PSYCHOTHERAPIST- PATIENT PRIVILEGE</u>
West Virginia				
Wisconsin	Civ.&Crim. Wis.Stat. Ann.sec. 905.04 (West Supp. 1987) & Wis. R.Evid.905. 04(1987)		Civ.&Crim. Wis.Stat.Ann. sec. 905.04 (West Supp. 1987) & Wis.R. Evid. 905.04 (1987)	
Wyoming	Civ.&Crim. Wyo. Stat. sec. 1-12- 101(a)(i) (1987)		Civ.&Crim. Wyo.Stat.sec. 33-27-103(1987)	

APPENDIX B

ARMY PSYCHIATRIST QUESTIONNAIRE: DATA SUMMARY

Questionnaires mailed-167 Responses-65 39%

(Note: Some questions were not answered. N=number answered)

1. How many respondents are currently licensed to practice psychiatry in at least one state?

(n=64)	Licensed-61	95%
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2. What was the average number of years they had been practicing psychiatry?

Average-12 years

3. What was the average number of patients they had treated during their careers?

Approximately-2000 patients

4. How many respondents know what testimonial privilege, if any, they have where licensed?

(n=62)	Answered-25	Correct-15	24%
		Incorrect-9	15%
		Did not know-38	61%

5. How many respondents know what testimonial privilege, if any, they have where practicing?(Those practicing in continental United States, Hawaii, and Alaska only).

(n=43)	Answered-16	Correct-7	16%
		Incorrect-9	21%
		Did not know-27	63%

6. How many respondents know whether they are required by state law where practicing to report acts of child abuse revealed by their patients?(Those practicing in continental United States, Hawaii, and Alaska only).

(n=45)	Answered-35	Correct-30	67%
		Incorrect-5	11%
		Did not know-10	22%

ARMY PSYCHIATRIST QUESTIONNAIRE: DATA SUMMARY

7. What offenses would respondents report to authorities if admitted in psychotherapy?

(n=63)	A. Child abuse	60	95%
	B. Patient danger to himself or others	14	22%
	C. Elder abuse	2	3%
	D. Spouse abuse	2	3%
	E. Security risks	2	3%
	F. Homosexuality	1	2%
	G. Treason	1	2%
	H. Planned crimes	1	2%

8. How do respondents treat confidential communications from nonmilitary patients compared to military patients?

(n=64)	Same	34	53%
	Protect nonmilitary more	30	47%

9. How many respondents have testified in a:

(n=64)	A. State administrative hearing	19	30%
	B. Military Administrative hearing	45	70%
	C. State trial	25	39%
	D. Federal trial	19	30%
	E. Military court-martial	50	78%

10. How many respondents have been ordered to reveal confidential information concerning patients in these proceedings?

(n=64)	Total	16	25%
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(Type of information):

A. Competency	6	33%
B. Acts of child abuse	3	17%
C. Other criminal acts	3	17%
D. Truthfulness	2	11%
E. Personal history	2	11%
F. Drug use	1	6%

APPENDIX B

ARMY PSYCHIATRIST QUESTIONNAIRE: DATA SUMMARY

G. Criminal behavior 1 6%

11. What advice do respondents give their patients concerning privilege? -

(n=61)

A. Commander can get access if he has a need to know	15	25%
B. Court can subpoena	13	21%
C. No advice until issue arises	12	20%
D. No privilege exists	11	18%
E. Limited privilege exists	7	11%
F. Written notice of limits	6	10%
G. Art 31b warning	4	7%
H. Do only what is in the best interests of the patient	4	7%
I. Absolute privilege exists	3	5%
J. Must report if patient is a danger to himself or others	3	5%

12. What code of ethics do the respondents follow?

(n=55)

A. American Psychiatric Association ethical standards	37	67%
B. Hippocratic Oath	16	29%
C. American Medical Association ethical standards	10	18%
D. Other	5	9%

13. How many respondents know they have no privilege in a federal court or a military court-martial?

(n=61)

Federal court	47	77%
Military court-martial	52	85%

14. What impact does the lack of privilege have on the respondent's ability to effectively treat patients?

(n=61)

None	20	33%
Little	25	51%
Significant	16	26%

APPENDIX B

ARMY PSYCHIATRIST QUESTIONNAIRE: DATA SUMMARY

15. How many respondents perceive a greater need for confidentiality of communications between psychotherapist and their patients than physicians and their patients?

(n=61)	Yes	43	70%
	No	18	30%

16. How many respondents favor a privilege in military courts-martial for psychotherapist similar to what exists for attorneys and clergy?

(n=61)	Yes	44	72%
	No	15	25%
	Unsure	2	3%

17. How many respondents would report to authorities if their patient admitted sexually abusing his four-year old daughter and the respondent determined that the child is still at risk?

(n=61)	Would report	60	98%
	Unsure	1	2%

(To whom? There may be more than one):

A.	Army family advocacy program or Social Work Service	60	98%	
B.	State authorities	18	39%	(n=46)
C.	Patient's commander	6	10%	
D.	Military police/CID	4	7%	

18. Same facts as 17, except now the respondent determines that the child is no longer at risk?

(n=60)	Would report	48	80%
	Would not report	8	13%
	Unsure	4	7%

(To whom? There may be more than one):

A.	Army family advocacy program or Social Work Service	47	78%
B.	State authorities	10	22%

APPENDIX B

ARMY PSYCHIATRIST QUESTIONNAIRE: DATA SUMMARY

19. How many respondents knew they were required to report such incidents, whether by state law or army policy?

(n=58)	Yes	53	91%
-	No	1	2%
	Unsure	4	7%

APPENDIX C

PROPOSED MILITARY RULE OF EVIDENCE

PSYCHOTHERAPIST-PATIENT PRIVILEGE

(a) DEFINITIONS

(1) A "patient" is a person who consults with or is examined or interviewed by a psychotherapist.

(2) A "psychotherapist" is (A) a person authorized to practice psychiatry in any state or nation or armed service, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug or alcohol addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation or armed service while similarly engaged.

(3) A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family

(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 or alcohol 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.

APPENDIX C

PROPOSED MILITARY RULE OF EVIDENCE

(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 so to do is presumed in the absence of evidence to the contrary.

(d) EXCEPTIONS.

(1) Condition an element of defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his defense.

(2) Abused or injured child. There is no privilege under this rule as to any communication relevant to an issue concerning the abuse or neglect of a child under the age of 16 years.

(3) National security interests. There is no privilege under this rule as to any communication relevant to an issue concerning the national security of the United States government.

(4) Proper administration of justice. There is no privilege under this rule as to any communication relevant to an issue which, in the opinion of the trial court is essential to the proper administration of justice.