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THIS ARTICLE DEALS with two special problems in the fields of confidentiality and privilege, which can be discussed together although they are not entirely related. These problems arise from a physician-patient relationship and are special by virtue of the fact that the patient has made himself a special object of public attention or public concern. The first of these is the problem of the physician who wishes to disclose information about an historical personage. The recent publication of Winston Churchill's medical history and conversations by his doctor, Lord Moran, brought this problem to the fore.[1] The second problem is the disclosure of information by a physician concerning patients who are *infamous* rather than *famous*. Charles Whitman, the Texas tower sniper and Lee Harvey Oswald, are prototypes of this group of patients.

The physician's concern with confidentiality and privilege traditionally has had two main divisions. Confidentiality relates to the problem of the physician who, in the course of his duties, told others that a patient had a venereal disease or was an alcoholic or revealed some other information for which the patient might be held up to public scorn.[2] The question here was whether the circumstances under which the defamatory or actionable disclosure was made were a defense to an action for libel or slander. Privilege concerns rules of evidence related to the behavior of the physician on the witness stand and whether he can refuse to give information because of the special character of the doctor-patient relationship.[3]

In recent years less obvious and more subtle problems have come to the fore, partly under the stimulation of increased third party relationships. We have had cases concerning the right of the patient, or his representative, to have access to his hospital records,[4] technical legal questions concerning waiver of privilege when a patient himself has voluntarily testified about the matter at issue,[5] public concern about the protection

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1 Moran, Churchill, Taken from the Diaries of Lord Moran (1966).

2 Slovenko, Psychotherapy, Confidentiality, and Privileged Communication 16 (1966).

3 97 C.J.S., Witnesses § 293 (1957).

4 Wallace v. University Hosp. of Cleveland, 84 Ohio L. Abs. 224, 170 N.E.2d 261 (1960), *appeal dismissed* 171 Ohio St. 487, 172 N.E.2d 459 (1961); Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n., 191 F. Supp. 51 (W.D. Okla. 1961); Pyramid Life Ins. Co. v. Gleason Hosp. Inc., 188 Kan. 95, 360 P.2d 858 (1961).

5 Hogue v. Massa, 80 S.D. 319, 123 N.W.2d 131 (1963); Ausdenmoore v. Holzback, 89 Ohio St. 381, 106 N.E. 41 (1914). In Mathis v. Hilderbrand, 416 P.2d 8 (Alaska 1966), commencement of a personal injury action was held to constitute waiver of the privilege by the plaintiff.

due to patients who are the subject of medical experiments and new procedures, i.e. protection not only of these patients' physical well-being but also of their right to privacy.[6] We have had statutory regulations protecting the physician who reports cases of battered children,[7] and recently we have had highway safety authorities who wish to press for similar protection to physicians who report on patients whom they feel may not be in good enough physical or emotional condition to drive.[8] Air safety experts similarly seek methods to protect physicians who report on patients who might not be safe pilots.[9]

This article focuses on two special problems which are of unusual medico-legal interest because the layman's misunderstanding of the nature of the doctor-patient privilege has led to mistaken attitudes and loose statements about standards of confidentiality.

Let us start with a few generalities about confidentiality and privilege. These topics are grouped together because they both concern disclosure of information by one in a position of special trust. Confidentiality is a broad topic dealing with ethics and good taste and respect for the patient's desire for privacy as much as it does with law. Legal redress is rarely sought and rarely secured for a breach of medical confidence.[10]

Privilege is a narrower concept concerning the right of the patient to have private matters excluded from testimony of his physician in a judicial proceeding. Privilege is based on statutory provisions modeled after the husband-wife and attorney-client relationships. The privilege of having the testimony excluded is not that of the physician, but that of the patient.[11] We should note that the common law did not grant privilege in the physician-patient relationship.[12] The medical privilege in this country is a statutory innovation originating in New York in 1828 and which has been adopted by a majority of the states and the District of Columbia. Most of the statutes limit the privilege to the courtroom

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[6] Hyman v. Jewish Chronic Disease Hosp., 15 N.Y. 2d 317, 258 N.Y.S. 2d 397, 206 N.E. 2d 338 (1965).

[7] Reinhart and Elmer, The "Battered-Child" Laws, 1967 Nat'l Medicolegal Symposium 138; Comment: Legislation as Protection for the Battered Child, 12 Vill. L. Rev. 313 (1967).

[8] Some physicians state that medical examinations on a selected basis, although helpful in picking up some medical conditions, do not effectively control the chronic alcoholic and they suggest that ultimately the personal physicians may have to take the responsibility of informing authorities; Rosenow and Watkins, What the Doctor Can Do to Cut the Traffic Toll, Modern Medicine 44 (June 5, 1967).

[9] Blanc reports important psychopathology in a majority of flying personnel that his group studied; Blanc *et al.*, 37 Aerospace Med. 70 (1966).

[10] Bergen, Keeping the Patients' Secrets, 195 J.A.M.A. 227 (Jan. 31, 1966).

[11] DeWitt, Privileged Communication Between Physician and Patient 43 (1958); See also 97 C.J.S., Witnesses § 293 (1957).

[12] 97 C.J.S., Witnesses § 293 (1957).

situation, and these statutes have usually been construed narrowly.[13]

I have said that the physician's concern with confidentiality and privilege has traditionally had two divisions. These generally arise in separate and distinct situations. Confidentiality is of concern in connection with disclosures made outside of court while privilege relates to disclosures in judicial proceedings. Thus an English physician's requirements to observe principles of *confidentiality* in the absence of the doctor-patient privilege do not vary a great deal, for instance, from the principle of confidentiality observed by the physician in New Mexico, where privilege exists concerning venereal or loathsome disease and workmen's compensation cases,[14] or principles of confidentiality observed in New York, where the statute confers a general doctor-patient privilege for the courtroom situation.[15] Privilege thus depends on the statutory law of the jurisdiction while principles of confidentiality are more uniformly adhered to.

One reason confidentiality and privilege tend to be confused by the lay public is that the phrase "physician's qualified privilege" is often used to describe instances where confidentiality can be breached without fault, and the use of the word "privilege" has led to confusion with the statutory privilege affecting testimony in court.

The problems of the famous and infamous patient discussed in this article relate to confidentiality and those situations where confidentiality can be breached without fault or guilt rather than to privilege. We are concerned with privilege in order to point out how it has been mistakenly brought into discussions concerning these problems.

Famous Persons

When Lord Moran, Winston Churchill's personal physician and constant companion from 1940 until Churchill's death, published a biographical book about his famous patient and friend there was general indignation. The book was based on the diaries Moran had kept during this whole period. Cassandra, the London Daily Mirror columnist, said Lord Moran "should have been silent about what the doctor saw."[16] The Lancet, a British medical publication, pointed out that the public's trust in the medical profession derives largely from the conviction that what transpires between patient and doctor will not be bandied about. The Lancet claimed that if this confidentiality is owed to the living, it is doubly owed to the dead (Lord Moran had waited until the death of his famous patient before publishing). The Lancet further stated that by

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[13] *Ibid;* Slovenko, *op. cit. supra* note 2, at 15-18.

[14] N.M. Stat. Ann. § 20-1-12.

[15] N.Y. Civ. Prac. Act §§ 352, 354.

[16] Cassandra, Fascinating Bad Taste Marks Record of Churchill's Decline, Philadelphia Inquirer, May 30, 1966, at 11.

writing publicly about the medical condition of an identifiable patient, Lord Moran had created a precedent which none should follow.[17] The Representative Body of the British Medical Association at its next annual meeting, although without direct reference to Lord Moran, resolved (with only three dissenting votes in the 560-seat body) that the "death of a patient *does not* absolve the doctor from his obligation of secrecy." [18]

Why the great outcry? The book contains two types of revelations. One is the chronicling of what Churchill did and said, his encounters with Roosevelt and Stalin, and his remarks on the conduct of the war, his opponents, and Parliament. Lord Moran was Churchill's physician but he was the recipient of these confidences not in his role as a physician but in another role, call it friend, confidant, or whatever. To be present at historical meetings is not a part of the physician's role, and if a physician by chance is present it would seem he would have as much right to leave a record for history as any other attending person.

The second type of revelation concerns Churchill's physical condition: His series of strokes; his gradual deterioration; and his attempt to maintain his prestige and power in the early 1950's. When Churchill had his stroke in 1953, the public was informed that he was suffering from giddiness and would need a month's rest. Eventually, four months after the stroke, the time came when an important public occasion could not be delayed. Churchill journeyed to Margate to deliver a major address to the Conservative Party. If the party and the public knew the true nature of his illness he could not hope to retain his office.

In his diary Lord Moran wrote: ". . . I can picture the sea of faces peering up at him. Will they notice anything different in him? Will they see that his mouth droops at the left side, that he does not swing his left arm, that his walk is unsteady when he's tired? Will they hear that his articulation is not so clear when he comes to the end of his speech?" [19] Churchill rose to the occasion; the test was passed; he remained Prime Minister for two more years. I wonder if the British doctors who struck out at Lord Moran for his *breach of confidentiality* in letting information of this kind be known, long after it had become history and when Churchill's death had made it impossible for harm to result from disclosure, were not in fact reacting to their chagrin; they had not picked up the mouth droop, the unsteady walk, the slurred speech.

Lord Moran has had defenders. Historians have said his account is invaluable. One medical reviewer has said that Lord Moran "has added the missing facet to Churchill by making his medical record public. A figure such as Churchill cannot have any privacy. He belongs to the

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[17] Lister, By the London Post, 247 New Eng. J. Med. 1497 (1966).

[18] Med. Trib., July 25, 1966, at 2.

[19] Moran, *op. cit. supra* note 1, at 508.

world, alive or dead, and anything related to him, especially his health problems, are of universal interest." [20]

We live in a time when public figures, alive and dead, are the subject of biographies by their secretaries, assistants, even by their children's nursemaids in the cases of British royalty and the Kennedy family. It is a staggering proposition to insist that all others in society can write about public figures, and the doctor alone cannot. We know that Darrow, Nizer, and Edward Bennett Williams have all written about their clients.

The test to be applied to an alleged breach of confidence between an attorney and his client is the same as that which applies to the physician-patient relationship. The elements of this test are: (1) was the subject matter disclosed to the confidant in the course of securing help or treatment, and which would not have been disclosed except in the process of gaining such help; and (2) was the information, if divulged, fitting to be spoken.

The public seems to have a morbid desire to know many details including the last words of the illustrious on their deathbeds. Physicians have traditionally satisfied this curiosity and they have not been criticized for doing so. Deathbed utterances are generally not made to aid in securing treatment, and physicians have felt they could reveal the statements since they did no discredit, and often did great credit, to the illustrious dead.

Why all the fuss about Lord Moran? He had done what many physicians to the illustrious had done; that is, waited until the deaths of their patients and then divulged information not revealed as an essential part of securing treatment and not discrediting the dead. When the charge of abuse of confidence and violation of privilege began to be heard, the pack was soon in full cry, mindless of the tradition in medicine of reporting on the famous dead.

Examples are numerous. Marat, murdered in the bathtub by Charlotte Corday, was later the subject of his physician's case report concerning his scrotal and perineal dermatitis, the cause of the watery soaks which made him such an easy target.[21] Napoleon's medical progress and his behavior were the subject of the reports of his physician at St. Helena.[22]

In American history there are numerous examples of reports about identifiable patients, particularly during major illnesses and after the death of Presidents. No one suggested that this would impair the confidence of all future patients in future doctors, the rationale that is usu-

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[20] MD, May 1967, at 279.

[21] MD, April 1967, at 178.

[22] Arnott, An Account of the Last Illness, Decease and Post Mortem Appearances of Napoleon Bonaparte (1822).

ally given by those who feel that complete confidence should be the rule. The progress towards death of our first three assassinated presidents, Lincoln, Garfield and McKinley, was chronicled by their physicians.

We also have examples of presidential illnesses which were kept closely guarded secrets at the time they occurred but were later publicly described. Twenty-four years after it took place, the full account of President Cleveland's two operations for oral cancer appeared in the *Saturday Evening Post,* written by Dr. William W. Keen, Professor of Surgery at Jefferson Medical College.[23] Dr. Keen had been the junior surgeon when the operations were performed. The details of the President's illness were kept secret because the country was on the verge of a serious financial crisis. Dr. Joseph D. Bryant, the surgeon in charge of the President who performed the operation and was the President's spokesman to the press, minimized the illness as post-extraction difficulties in connection with a toothache. Bryant denied a published report that the President had been operated on for a cancerous growth in the mouth on board the yacht *Oneida.* One of the reasons that Dr. Keen gave for publishing the *Saturday Evening Post* account of the operations and the national economic and political complications which could have been occasioned by the President's illness, was his desire to make amends to the resourceful reporter who had managed to secure details of the operation and had written an accurate report which was branded as untrue. Dr. Keen wrote that "the entire left upper jaw was removed from the first bicuspid tooth to just beyond the last molar, and nearly up to the middle line." [24] Because the operation was done entirely within the mouth without any external incision and because a little more than a month later the President was able to speak in a normal voice with the aid of a rubber prosthesis, the public was spared the knowledge that its hard currency President had cancer and that its soft currency vice president, the first Adlai Ewing Stevenson, stood a good chance of succeeding to the presidency.

Vice-Admiral Ross T. McIntire, Franklin Roosevelt's physician, wrote *White House Physician* in collaboration with George Creel in 1946. Like Lord Moran he describes his travels with Roosevelt and the political events he witnessed as well as his patient's medical condition. McIntire had found the President generally sound for a man of his age and he states his death from a cerebral hemorrhage could not have been predicted.[25] On the other hand, Irwin Richman of the William Penn Museum, writing in a recent issue of *Pennsylvania Medicine,* indicates that the public was uninformed about the President's series of "little

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[23] Reprinted with additions in Keen, The Surgical Operations on President Cleveland in 1893 Together with Six Additional Papers of Reminiscences (1928).

[24] *Id.* at 59.

[25] McIntire, White House Physician (1946).

strokes," arteriosclerosis, and a series of respiratory inflammations ranging from colds to severe bronchitis. Like Churchill and Cleveland, Roosevelt scotched rumors of bad health by a public appearance, in this case by his famous ride through New York City in the 1944 campaign bareheaded on a cold rainy October day.[26]

Three other deceased Presidents of recent memory, Wilson, Harding and Kennedy, have been the objects of rumors concerning illness. In these cases their physicians have not shared with the public the medical histories of their late patients, perhaps out of a respect for confidentiality. In the case of Wilson, his physician, Dr. Grayson, cooperated with Mrs. Wilson to keep information about the President's stroke from the nation.[27] Harding's sudden death has been called mysterious.[28]

In Kennedy's case, the full details of his adrenocortical deficit, the medications he was receiving, as well as the extent of his orthopedic problem have never been made public. The editor of West Germany's leading news magazine, *Das Stern,* has said that Kennedy was suffering from Addison's disease and the desire of his family to keep this secret is the reason autopsy X-rays have not been made available to investigators.[29] Drew Pearson has written:

> When the late President Kennedy was a candidate for the Democratic nomination, the report persisted that he was suffering from Addison's disease. However, this was emphatically denied by the Kennedy family. Later, many physicians pointed out that the swelling of the late President's face—he became much fuller-faced after entering the White House—was the result of cortizone, which he had been taking in heavy doses to check Addison's disease.[30]

It is a characteristic of the health reports which the doctors of Presidents reveal to the press that they tend to emphasize normal findings and eliminate adverse material. Roosevelt's arteriosclerosis and Kennedy's adrenocortical and orthopedic problems were equally soft-pedalled. Until the Warren Commission report it was not known, for example, that at the time of the assassination President Kennedy was wearing not only a back brace consisting of a tightly laced canvas corset with metal stays but also a knitted elastic bandage around the lower portion of his body in a "figure-eight" arrangement between the legs and around the brace which gave added rigidity and support. Dr. John Lat-

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[26] Richman, Medical Secrecy, Penna. Medicine 90 (April, 1967).

[27] Smith, When the Cheering Stopped 90 (1964).

[28] Ray Lyman Wilbur both in a Saturday Evening Post article in 1923 and in his autobiography, Memoirs of Ray Lyman Wilbur, 1875-1949 (1960), has denied that there was anything mysterious regarding Harding's death. Dr. Wilbur was present as a consultant during Harding's last illness and states that death was due to natural causes—either a cerebrovascular accident or a coronary occlusion.

[29] Quoted by Drew Pearson, Philadelphia Bulletin, Dec. 5, 1966, at 52.

[30] *Ibid.*

timer, writing in the *Journal of the American Medical Association,* has speculated this brace coincidentally may have been a factor in the President's death since it kept him from toppling or crumpling after being hit by the first bullet.[31] Dr. Lattimer also notes that the autopsy record does not include any mention of the adrenal glands, either gross or microscopic although the kidneys are well described.[32] Dr. Milton Helpern, however, feels that autopsy material on adrenocortical function is not a matter for public scrutiny.

> Some of my colleagues also argue that if the autopsy findings did show a deterioration of the adrenal glands . . . it is a missed opportunity for showing the progress of medicine . . . in general to fail to disclose it. . . . [I]t would dramatically show medicine's progress if a man with Addison's disease could be treated so successfully that he could function well enough to perform the duties demanded by the office of President of the United States.
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> I still go along with the feeling that any disclosure in the autopsy findings over and above the bullet wounds which produced the President's death must be considered a private matter for the family to do with as they personally desire.[33]

I do not agree with Dr. Helpern. Such matters as the brace are of minimal significance, but they serve as examples of information withheld from the public while the fiction of open revelation is maintained. The adrenal status is much more significant since psychological effects of cortisone conceivably could have been a factor in the making of major Presidential decisions. In addition, major adrenal problems were denied by the physicians issuing a report on Kennedy's health status during the 1960 campaign.

The autopsy photographs and X-rays, by common understanding always the property of the hospital where the autopsy took place, are not in the files of the Bethesda Naval Hospital. They were given to the Kennedy family under circumstances which have never been clarified. In response to some furor over this matter the Kennedy family, which had previously persistently denied possession of the films, turned this material over to the National Archives in November 1966 with a limitation that public inspection will not be allowed during the lives of the immediate Kennedy family.[34]

The principle followed by the doctors of the politically great during their lives appears to be selective release of public information, although the public is encouraged to believe the whole truth is being bared. The physician is thus not only a doctor to his patient, but he also fulfills

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[31] Lattimer, Factors in the Death of President Kennedy, 198 J.A.M.A. 327 (Oct. 24, 1966).

[32] *Ibid.*

[33] Dr. Milton Helpern as quoted by Houts, The Warren Commission Botched the Kennedy Autopsy, Argosy, July, 1967, at 116.

[34] Time, Nov. 11, 1966, at 33.

a public role, that of giving reassurance to the public concerning the health of its elected officials.

I submit that under such circumstances there can be justifiable exceptions to the principle that the patient's state of health is a private rather than a public matter. Certainly during the lifetime of the patient his doctors should not reveal information without his consent. After his death it would seem appropriate to set the record straight in the hopes that history's lessons can be useful in the evaluation of similar situations which inevitably arise.

There have always been four exceptions to the ideal of confidentiality in the doctor-patient relationship: (1) disclosures which must be made by law, such as the reporting of tuberculosis or venereal disease or the requirements by some states that knife and gunshot wounds be reported to the police;[35] (2) disclosures which must be made in court either because no privilege exists or the court rules that privilege does not apply; (3) disclosures made at the request of the patient, such as the notification to insurance companies, employers, or family members if the physician feels that such disclosures are appropriate;[36] and (4) disclosures made because in the opinion of the physician there are clear dangers to the patient or to society, such as the possibility of violence, if the confidence is kept.[37]

It seems appropriate to state that the medical condition of public figures, who manipulate medical reports as part of their attempt to secure and maintain public confidence, should be a fifth exception. Disclosures made for the sake of historical accuracy, to set the record straight, after the deaths of such statesmen seems to me to be a reason for divulgence which is justifiable equally with the reasons for the noted exceptions.

Infamous Persons

Our second problem concerning confidentiality involves psychiatrists more than other physicians, and the patient concerned is a public figure not because he is illustrious, but because he is infamous. If a Texas sniper or a Presidential assassin is dead, can details of his psychiatric

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35 Moritz and Stetler, Handbook of Legal Medicine, at 200-04 (2d ed. 1964).

36 DeWitt, *op. cit. supra* note 11, at 108 et seq. deals with the problem of third party relationships and confidentiality.

37 Bergen, *op. cit. supra* note 10 gives as the four exceptions to the principle of confidentiality (1) prior assent by the patient; (2) when disclosure is required by statute or court order; (3) when the person disclosed to needs the information for the benefit or welfare of the patient; and (4) when the information is essential for the protection of society in general. The Utah Supreme Court has said that the protection of society includes warning a prospective bride that her prospective husband is a psychopathic personality and has a poor character: Berry v. Moench, 8 Utah 2d 191, 331 P. 2d 814 (1958). Most medical authorities would feel this decision is extreme and if widely applied would threaten the entire confidential relationship between patient and doctor; Robitscher, Pursuit of Agreement: Psychiatry and the Law, at 228-30 (1966).

history be revealed to the public? In 1960 Vernon Mitchell, an employee of the National Security Agency, defected to the U.S.S.R. and his psychiatrist testified under subpoena before a closed and secret session of the House Un-American Activities Committee.[38] After the inevitable "leak" to the press, the physician was accused by some doctors of violating the principle of complete confidentiality and impairing all potential doctor-patient confidences.[39]

Getting off on the wrong foot and confusing confidentiality and privilege, the medical society of the State of Maryland, known as the Medical and Chirurgical Faculty, where the physician practiced, declared that he had not violated the law of Maryland since there was no law of privileged doctor-patient communication.[40] Since the proceeding was not a trial, since it was secret, and since the patient was not present to claim his privilege, the matter seems to me more like a possible breach of confidentiality than a violation of privilege.

The physician was defended by some on the ground that his information was vital for national security,[41] but possibly the doctor could have satisfied the committee with negative rather than positive disclosures, such as the fact that the patient had revealed no wide-scale plot against the government and had not shown he had access to important information rather than such positive disclosures as sexual abnormality and marital discord. Although the physician was perhaps more defended than censured, some commentators have said that in the absence of the ability to prevent a specific crime he should have refused to testify.[42]

The University of Texas psychiatrist who released the contents of a psychiatric interview with Charles J. Whitman after his death in order to provide light on the 17 murders and the wounding of 26 more victims in the summer of 1966 has been more widely criticized. Perhaps this was because his information was freely given to the press and was not in response to a court order or subpoena. A group of opinions gathered by *Psychiatric Progress* shortly afterwards, again as in the case of Lord Moran without direct reference to any individual or circumstance, stressed the adverse effect on future confidences, especially on students in the college health service setting, by disclosure of any confidential material.[43]

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[38] Sidel, Confidential Information and the Physician, 264 New Eng. J. Med. 1133 (1961) for a complete account of the controversy about confidentiality that followed the Mitchell defection.

[39] Adland, letter to editor of The Washington Post, Sept. 24, 1960.

[40] The Washington Post, Sept. 24, 1960, § C at 1.

[41] *Ibid.* The Medical and Chirurgical Faculty of the State of Maryland in its vindication of the psychiatrist stated "that the interests of the nation transcend those of the individual."

[42] Robitscher, *op. cit. supra* note 37, at 234-37.

[43] Psychiatric Progress, Sept.-Oct. 1966, at 2.

Dr. C. Hardin Branch stated that only in the case of legal requirements to provide information and in the case of minors whose parents must be informed on some phases of psychiatric progress is breach of confidence justified.[44] Dr. Dana Farnsworth stated that "in general we at Harvard follow the policy of never violating confidence unless we have a legally proper subpoena, and then only after discussing it with counsel." [45] The late Dr. Manfred Guttmacher said that a physician should report confidential information only if required to do so in an open court hearing, or if the material had previously been released, or when there is a real danger that the patient will carry out some dangerous act.[46]

Writing in *The New Republic,* Dr. Robert Coles said,

> I do not know why the officials in the university infirmary decided to break the utter confidentiality that must protect medical records. No one can deny an eager press and an anxious public the information they have a right to learn. A summary statement could have been issued, and certainly the doctor interviewed; but for a patient's entire psychiatric record to have been instantly made available for no explicit medical reason seems to me at least a panicky reaction to a stressful situation.[47]

But once one admits, as Coles has, that the public and press have a right to information, was the psychiatrist so wrong in releasing his report? The harm, if any, was perhaps more to Whitman's living relatives, particularly his father, than to the dead man, his murdered mother and wife or to the potential of the doctor-patient relationship of prospective patients. In a similar situation involving Lee Harvey Oswald, no one protested when information was released concerning his examination as an adolescent by a psychiatrist and the recommendation of psychiatric treatment (which recommendation was not accepted).

United States District Judge M. Joseph Blumenthal has recently ruled that a prisoner has no right of privacy.[48] Without his knowledge, a convict's parole hearing at a Connecticut prison was secretly filmed and recorded by a Hartford television station for a documentary on prison life. The convict sought $50,000 damages for invasion of privacy. The judge stated that a "full-fledged citizen" might have been entitled to sue but a "prisoner becomes a public figure by virtue of his crime and subsequent arrest."

We can note also such recent cases as *New York Times Co. v. Sullivan*[49] and *Pauling v. St. Louis Globe Democrat*[50] in which the idea of

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[44] *Ibid.*

[45] *Ibid.*

[46] *Ibid.*

[47] Coles, American Amok: Is the Gun-Ridden USA a Violent Nation?, The New Republic, Aug. 27, 1966, at 13.

[48] Travers v. Paton, 261 F. Supp. 110 (D. Conn. 1966).

[49] 376 U.S. 254, 84 S. Ct. 710, 11 L.Ed.2d 686 (1964).

[50] 362 F.2d 188 (8th Cir. 1966), *cert. denied,* 388 U.S. 909.

absolute privacy from press coverage has run head on into constitutional guarantees of freedom of speech and press. Perhaps when a person achieves the status of a public personage, whether it is by running for office, by defecting to Russia, by murdering a President or whatever, there is a waiver of doctor-patient confidentiality along with other aspects of the right to privacy when the public good can be served by disclosure and when the patient is dead and can no longer be harmed by disclosure.

Another recent case involves a notorious patient who is not dead and who may have been adversely affected by medical disclosures. Dr. Marvin Ziporyn, the Cook County, Illinois, psychiatrist who treated Richard Speck for 100 hours between his arrest and trial, announced that he would publish a book about Speck.[51] The announcement came between the conviction of Speck, whose defense was based on an alibi and the allegation of misidentification, and the pronouncement of sentence of death.[52] The book was not to be published until after the sentence, presumably so as not to prejudice the judge when he passed sentence. Cannot the fact that such a book is in the process of publication carry with it the implication that the defendant did commit the crimes—otherwise why waste 100 hours in psychiatric interviews if all the defendant says is that he did not commit the crimes? Dr. Ziporyn said publicly, prior to sentencing, that he was determined to put his information on Speck in the form of a book because of "the unique opportunity to acquire data on mass murderers. . . . Most of these fellows are out and out psychotic or they are dead. In this relationship we had 100 hours of therapy with a patient who is verbal, communicative, and could express himself and shed a good light. Consequently, I felt this was something of benefit to the community." [53] The psychiatrist had Speck's release. We do not know if Speck and his attorney wanted this information available to the court as part of the presentencing report procedure, in which case the announcement of the book could carry with it no new information which could prejudice the court, or if the announcement of the forthcoming book had also been news to the sentencing judge.

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[51] AMA News, May 8, 1967, at 1.

[52] In reporting on the passing of sentence on Speck, The Philadelphia Inquirer, June 6, 1967, at 15 noted:

> Obviously irritated by reports that a number of "instant books" are being written about the Speck case, Judge Paschen made an unusual order.
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> He agreed with [Public Defender] Getty's contention that the convicted murderer is without funds, but warned that if Speck receives money from any books or magazine articles, it must be used to pay for a transcript of the trial.
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> A transcript of the trial will be needed in the filing of an automatic appeal to the State Supreme Court.

[53] *Supra* note 51.

Conclusion

Our period in history is characterized by increasing complexities which lead to alterations and modifications even in such time-honored concepts as the confidentiality of the doctor-patient relationship. It is also characterized by mass communications which make it both more difficult and more necessary to maintain privacy. All medicine has felt the impact of these forces although perhaps they have raised more problems in psychiatry than in other branches of medical practice. Freudian or dynamically-oriented psychotherapy depends on the furnishing by the patient to the doctor of uncensored thoughts, wishes, and memories.

The problem of the psychiatrist in third party relationships, such as the role of Dr. Ziporyn in the Speck case, is particularly complicated. The psychiatrist is not paid by the patient but by an employer, usually a court or an administrative governmental agency, to furnish material. But the material furnished depends on the cooperation of the patient and it may be self-incriminating for the patient.

The special problem involving psychiatrists should not obscure the fact that the concept of confidentiality in all medical relationships is becoming more diffuse for at least four reasons: (1) third-party relationships have invaded all phases of medicine; (2) modern medicine demands that the whole person be treated, not just the arm, the leg, or the abdomen, and emotional factors once considered the province of the psychiatrist are increasingly the concern of all physicians; (3) modern methods of communication have made novel medical techniques (such as organ transplants) and the medical problems of illustrious patients (such as the state of health of chiefs of state) the subject of rapid worldwide news dissemination with consequent increase of public interest; and (4) the closer concentration of people in a high density society makes the ideal of confidentiality harder to maintain, particularly when we reflect that the physician may have knowledge that a patient is dangerous and that unless the potential danger is called to attention, harm may result.

Despite some disagreement about privilege and about how much secrecy must be maintained in the courtroom situation where the physician may be in a position to help or hinder the court in its search for truth, there is little disagreement that confidentiality is an essential ingredient in the physician-patient relationship. There is essential agreement when certain kinds of emotional illnesses are being treated. No one advocates, and I would not advocate, the diminution of the degree of confidentiality that the medical profession maintains; on the contrary, cases such as *Berry v. Moench*[54] and such authorities as Sidel[55] and Hollender[56] indicate the need for more stringent standards.

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[54] *Supra* note 37.

[55] *Supra* note 38.

(Continued on next page)

But there are four well-recognized exceptions to the ideal of complete confidentiality in the doctor-patient relationship: when the patient has given prior assent;[57] when disclosure is required by statute or court order;[58] when there is a necessity to disclose for the benefit or welfare of the patient;[59] and when the information is essential for the protection of society in general.[60] Perhaps the need of the public to know and its right to know make fifth and sixth exceptions desirable. These are: (5) the disclosure of information about the famous, when the public has not been allowed access to this information during their lives and when they are safely dead, providing that they have partially or incompletely furnished such information to the public and thus acknowledged the public's right to know; and (6) the disclosure of similar information about the infamous when their activities have made them so much a matter of public concern that they can be considered to have forfeited certain rights of privacy which unquestionably belong to less public citizens.

(Continued from preceding page)

[56] Hollender, The Psychiatrist and the Release of Patient Information, 116 Amer. J. Psych. 828 (1960); Privileged Communication and Confidentiality, 26 Diseases of the Nervous System 169 (1965).

[57] *Supra* note 36.

[58] *Supra,* note 35.

[59] *Supra,* note 37.

[60] *Ibid.*