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The Psychiatrist-Patient Privilege in Illinois

INTRODUCTION

The psychiatrist-patient privilege has been legally recognized in Illinois for more than twenty-five years. Initially arising by court sanction, this privileged relationship received legislative endorsement in 1963. Recognizing both the expanding role of psychiatry in

1. The psychiatrist-patient privilege is an evidentiary rule which permits the patient to prevent disclosure of communications made to a psychiatrist in a professional setting.


As repealed, 5.2 provided:

5.2 Psychiatrist-patient relationship
In civil and criminal cases, in proceedings preliminary thereto, and in legislative and administrative proceedings, a patient or his authorized representative and a psychiatrist or his authorized representative have the privilege to refuse to disclose, and to prevent a witness from disclosing, communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and such persons under the supervision of a psychiatrist in the accomplishment of the objectives of diagnosis or treatment.

There is no privilege under this Section for any relevant communications.

(a) when a psychiatrist, in the course of diagnosis or treatment of the patient, determines that the patient is in need of hospitalization, provided that such communications shall be admissible only with respect to issues relating to the need for such hospitalization;

(b) if the judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychiatrist in the course of a psychiatric examination ordered by the court, provided that such communications shall be admissible only with respect to issues involving the patient's mental condition;

(c) in a civil or administrative proceeding in which the patient introduced his mental condition as an element of his claim or defense or, after the patient's death, when his mental condition is introduced by any party claiming or defending through or as a beneficiary of the patient; the provisions of this paragraph (c) shall not apply to preclude the assertion of the privilege in any action brought or defended under the "Illinois Marriage and Dissolution of Marriage Act," as now or hereafter amended, unless the patient or the psychiatrist on behalf of the patient first testifies as to such communications;

(d) in any proceeding brought by the patient against his psychiatrist, including but not limited to any malpractice proceeding, and in any criminal or license revocation proceeding in which the patient is a complaining witness and in which disclosure is relevant to the claim or defense of the psychiatrist.

As used in this Section, "patient" means a person who for the purpose of securing diagnosis or treatment of his mental condition consults a psychiatrist; "psychiatrist" means a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed
contemporary society and the public interest inherent in the matter, the general assembly molded an inclusive statute to administer the privilege. In an effort to provide a broader, more comprehensive privilege, the Illinois legislature recently repealed the existing statute and replaced it with a privilege encompassing the psychiatrist, psychologist, social worker, nurse, and others providing similar services. The new enactment, effective January 1, 1979, is entitled the "Mental Health and Developmental Disabilities Confidentiality Act."

This article will examine the impact of the new statute on the previous state of the law with primary focus on the current status of the Illinois psychiatrist-patient privilege. Emphasis will be directed at pre-existing ambiguities resolved by the Act and at those which remain unattended. Finally, this article will conclude with an analysis of the legislature’s innovative approach to matters never considered under the prior psychiatrist-patient privilege.

The Historical Development of Privilege

Before the early 1800's, the only professional privilege recognized in American common law was that granted to attorney-client communications. Physicians could not refuse to testify, and a psychiatrist-patient privilege was beyond consideration, as the field of psychiatry was virtually unknown to the public. New York enacted the first statute granting a physician-patient privilege in 1928, and numerous states then followed suit. The psychiatrist was included within the physician-patient privilege, because psychiatrists were considered nothing more than specialized medical practitioners. Despite this multi-jurisdictional trend, there was disagreement among commentators regarding the privilege.

by the patient to be so qualified; "authorized representative" means a person empowered by the patient or the psychiatrist to assert the privilege and, when given permission by the patient or the psychiatrist, to make disclosure of communications made privileged by this Section.

6. Id. § 1.
7. 8 J. Wigmore, EVIDENCE § 2285 at 527 (McNaughton rev. 1961) [hereinafter cited as Wigmore]; Note, Confidential Communications to a Psychotherapist: A New Testimonial Privilege, 47 NW. U. L. REV. 384, 385 (1952) [hereinafter cited as Confidential Communications].
Wigmore believed that a separate physician-patient privilege was not justified. He based this conclusion on his proposed framework for determining whether a common law privilege should be extended. He suggested that any privilege against disclosure of a particular communication must satisfy all of the following fundamental conditions: (1) the communication must originate in the confidence that it will not be disclosed; (2) the element of confidentiality must be essential to the effective integrity of the relationship between the parties; (3) the relationship must be one which in the opinion of the community deserves sedulity; and (4) the injury inuring to the relationship by the disclosure of the communication must be greater than the benefit gained from the correct disposal of the litigation. Wigmore concluded that his four canons did not justify the physician-patient privilege.

This finding was echoed by other legal scholars. Wigmore believed that the only support for extending this privilege, the concern with fostering the physician-patient relationship, was not alone sufficient to justify the privilege.

Despite Wigmore’s objections to the physician-patient privilege, several commentators submit that the psychiatrist-patient relationship satisfies all of Wigmore’s imperatives. Subsequent legislative action has been prompted by an increased appreciation of the critical need for confidentiality in a psychiatrist-patient relationship. Numerous states have enacted legislation granting a specific privilege to the communications between a patient and his psychiatrist.

9. Wigmore, supra note 7, § 2285. The four conditions have been cited and quoted extensively in legal writings and judicial decisions. See, e.g., Radiant Burners, Inc. v. American Gas Assn., 320 F.2d 314 (7th Cir. 1963); Morris v. Avallone, 272 A.2d 344 (Del. Super. Ct. 1970); Slovenko, Psychiatry and a Second Look at the Medical Privilege, 6 WAYNE L. REV. 175, 179 (1960) [hereinafter cited as Slovenko]; Confidential Communications, supra note 7, at 386.

10. Wigmore, supra note 7, § 2380a at 831.


12. Wigmore, supra note 7, § 2380a at 829.

13. See Louitel & Sinclair, supra note 8, at 52; Slovenko, supra note 9, at 184; Confidential Communications, supra note 7, at 387.


15. See note 14 supra.
These statutes were often far from precise. Prior to the passage of the Act, the Illinois statute was typical in its failure to produce specific and definitive illustrations of the exact scope of the psychiatrist-patient privilege. Under the repealed statute, it was not apparent whether the privilege barred disclosure of the mere fact of psychiatric consultation. No guidelines existed regarding disclosure in the event of an imminent threat of criminal conduct. The standing of the psychiatrist to prevent disclosure contrary to the express wish of the patient had remained an unattended question. Finally, the distinction between unprivileged observations and privileged communications continued unaddressed by the legislature. The Act has explicitly resolved the uncertainty inherent in the first three of these areas and by reasonable interpretation should adequately diminish any confusion caused by the fourth.

RATIONALE: THE NEED FOR CONFIDENTIALITY

The primary rationale for recognizing the psychiatrist-patient privilege is to protect the confidentiality of this communication. Absent protection of such intimate communications, persons in need would forsake treatment. Moreover, the effectiveness of existing treatment would suffer. The patient must feel secure, knowing that his disclosures will remain private, before he can escape his inhibitions and reveal his most guarded thoughts. The need to protect the patient’s freedom to speak openly and honestly cannot be exaggerated; it is the foundation of successful psychiatric treatment.

17. SLOVENKO, supra note 9, at 188; Note, Psychiatrist’s Duty to the Public: Protection from Dangerous Patients, 1976 U. ILL. L. F. 1103, 1113 [hereinafter cited as Psychiatrist’s Duty]. Both commentators would bar disclosure of the mere fact of having the privileged communication. Contra, WIGMORE, supra note 7, at 846; Confidential Communication, supra note 7, at 387; Jenkins v. Metropolitan Life Ins. Co., 171 Ohio St. 557, 173 N.E.2d 122 (1961) (physician not prevented from testifying that he was consulted on a certain date).
18. The court in In re Westland, 48 Ill. App. 3d 172, 175-76, 362 N.E.2d 1153, 1155-56 (1977) considered this distinction, but did not definitively resolve the matter.
21. See Taylor v. United States, 222 F.2d 398 (D.C. Cir. 1955). Defendant was permitted to raise psychiatrist-patient privilege and thus bar the testimony of a hospital psychiatrist. The defendant had admitted to the psychiatrist that he had earlier feigned the schizophrenic
method requires the patient to express everything which comes to mind, as inappropriate or absurd as it may seem.\textsuperscript{22} The patient's thoughts must be allowed to wander without restraint, so that the psychiatrist can elicit an accurate picture of the patient's thought processes.\textsuperscript{23}

The psychiatric patient's vulnerable condition must also be considered in determining the need for privileged communications. Psychiatric treatment often occasions social stigma,\textsuperscript{24} a particularly unfortunate circumstance, as it manifests a hyperbolized effect upon its sensitive recipients.\textsuperscript{25} Thus, the patient must be assured that his guarded revelations will be protected with the utmost care. He may be ridiculed for merely undergoing treatment, and should not be further burdened with the likelihood of disclosure.

\textbf{THE SCOPE OF THE PRIVILEGE}

\textit{The Forums Affected and Sanctions}

In language virtually identical to the repealed psychiatrist-patient privilege, the Act authorizes the application of the privilege "in any civil, criminal, administrative, or legislative proceeding, or in any proceeding preliminary thereto."\textsuperscript{26} The statute specifies only symptoms in order to be diagnosed incompetent to stand trial. Judge Edgerton, writing for the court, concisely states the need for trust and confidence in psychiatric treatment:

In regard to mental patients, the policy behind such a statute is particularly clear and strong. Many physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a psychiatrist must have his patient's confidence or he cannot help him.

\textit{Id. at 401.}

\textsuperscript{22} \textsc{Slovenko, supra note 9, at 186; Louisel & Sinclair, supra note 8, at 52. Cf. Rosenheim, Privilege, Confidentiality, and Juvenile Offenders, 11 Wayne L. Rev. 660, 670 (1965) (free disclosure is a \textit{sine qua non} to effective psychiatric treatment).}

\textsuperscript{23} \textsc{The Group for the Advancement of Psychiatry expressed this need to protect the confidentiality of the psychiatrist-patient relationship:}

\textit{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. . . . 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.}

\textit{Group for the Advancement of Psychiatry, 92 (Report No. 45, 1960), reprinted in Advisory Committee Note to Court Rule 504, 56 F.R.D. 183, 242 (1972).}

\textsuperscript{24} \textit{Psychiatrist's Duty, supra note 17, at 1112; Louisel & Sinclair, supra note 8, at 52.}

\textsuperscript{25} \textit{Psychiatrist's Duty, supra note 17, at 1112-1113; Goldstein & Katz, supra note 20, at 178.}

\textsuperscript{26} \textit{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 10(a), 1978 Ill. Legis. Serv. 1513 (West)(to be codified at Ill. Rev. Stat. ch. 91½, § 801 § 10(a)).}
a limited number of forums in which the privilege operates. The privilege is not intended to prevent unwarranted disclosure by the psychiatrist to third parties during informal conversations. It focuses entirely on testimonial disclosure.

A psychiatrist’s violation of the patient’s confidence, under the past psychiatrist-patient privilege, might in the exceptional case merit an action for libel, slander, or invasion of privacy. In direct contrast to the absence of sanctions under the repealed statute, the Act explicitly grants the aggrieved person an action for damages, injunction, or other appropriate relief. The Act further permits the court to award reasonable attorney’s fees and costs to the successful plaintiff, which should serve as a self-policing mechanism. To further ensure compliance with the Act, a criminal sanction has been incorporated which makes any knowing and willful violation of any provision of the Act a Class A misdemeanor. The repealed privilege statute omitted criminal and civil sanctions, and apparently the availability of comprehensive remedies reflects the legislature’s concern regarding violations of the Act.


29. The patient is not, however, without some protection from unwarranted disclosure in non-judicial settings. Psychiatry, like most professions, sets a requisite standard of conduct to be maintained by all members. This standard is embodied in the Psychiatrist’s Code of Ethics, which prohibits the professional from revealing confidences entrusted to him during medical treatment. The only exceptions are legal compulsion and circumstances such as disclosure necessary to protect the welfare of the patient or the community. AMA, PRINCIPLES OF MEDICAL ETHICS § 9 (1957), reprinted in Dangerous Patient, supra note 20, at 555.

30. See Herbert, Does the Law Seal the Doctor’s Mouth?, 52 J. MICH. ST. MED. SOC’Y 385 (1953); SLOAN & KLEIN, supra note 20, at 61 n.15. But cf. LOUISELL & SINCLAIR, supra note 8, at 33 (a successful suit, brought under the causes of action mentioned in the text, is rare).

31. Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 15, 1978 Ill. Legis. Serv. 1516 (West) (to be codified at ILL. REV. STAT. ch. 91 1/4, § 801 et seq.). The Act is unclear whether § 15 operates to preclude a common law action for libel, slander, or invasion of privacy by a person aggrieved by a violation of the Act. Certainly such a restrictive construction is not mandated. The matter may be purely academic, however, because the statutorily-created cause of action under § 15 of the Act is undoubtedly the most convenient avenue to pursue.

32. Id.

33. Id. § 16.
The Act contains an ambiguity which existed in the original psychiatrist-patient privilege, although it may now be of diminished significance. The previous and current privileges are restricted to communications between the psychiatrist and his patient, and each implicitly excludes the psychiatrist’s observations from its coverage.\footnote{34} A narrow construction of communication, as it is used in section 2(1) of the Act,\footnote{35} would only include verbal exchanges between the psychiatrist and patient while permitting disclosure of all nonverbal\footnote{36} communications. A broader interpretation would encompass both verbal and nonverbal communications. If particular information is adjudged to be observation rather than communication, the construction placed on “communication” would be decisive. The most imposing factor in the decision whether to apply a strict or broad construction to “communication” must be an attempt to effectuate the legislature’s purpose and spirit in enacting the Act. A reference to the preamble of the Act reveals a legislative intent “to protect the confidentiality of records and communications of recipients of mental health or developmental disability services.” The only judicial construction which reflects the underlying purpose of the Act is the broader interpretation of “communication,” encompassing verbal and nonverbal exchanges.

While the previous statute apparently overlooked the dichotomy between observation and communication, the Act may have tacitly addressed the issue. Section 3(b) of the Act\footnote{37} permits the psychiatrist to keep personal notes which are not subject to discovery in any judicial, administrative, or legislative proceeding.\footnote{38} Personal notes are defined to include “the therapist’s speculations, impressions, hunches, and reminders”\footnote{39} which may approximate a definition of “observation.”\footnote{40} The Act allows the psychiatrist to take written notes of nonverbal information and grants these notes even greater immunity from disclosure than portions of verbal communications.

\footnote{34}{Id. § 2(1); ILL. REV. STAT. ch. 51, § 5.2 (1977)(repealed 1978).}
\footnote{35}{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 2(1), 1978 Ill. Legis. Serv. 1510 (West) (to be codified at ILL. REV. STAT. ch. 91 1/2, § 801 et seq.).}
\footnote{36}{Id. § 3(b), 1978 Ill. Legis. Serv. 1511 (West).}
\footnote{37}{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 3(b), 1978 Ill. Legis. Serv. 1511 (West).}
\footnote{38}{Id.}
\footnote{39}{Id. § 2(4)(iii).}
\footnote{40}{Id. § 3(a).}
Privileged verbal communication remains subject to the many exceptions enumerated in the Act, while the personal notes are not subject to discovery in any legal or administrative proceeding.

Unlike the preferential treatment given to personal notes, the recipient's records kept by a therapist or by an agency in the course of providing mental health services are confidential but subject to the numerous exceptions provided in the Act. The previous psychiatrist-patient privilege, section 5.2, had endeavored to prevent the unauthorized disclosure of the privileged communications but the statute was silent concerning the confidentiality of the official records. Implicitly, however, the psychiatrist's records were subject to the identical provisions for confidentiality and waiver incorporated in the repealed psychiatrist-patient privilege. The Act emphasizes the inclusion of this additional element, the confidentiality of records, which will serve to alleviate the uncertainty existing under the previous statute.

The Illinois legislature has clarified an issue which had been neglected under the prior statute. Confidential communication, according to section 2(1) of the Act, includes information which indicates a person's status as a psychiatric patient. Prior to the Act, the courts and commentators had debated the propriety of treating this information as confidential, but neither side had emerged with a majority. By extending confidentiality to include the mere fact of treatment and the patient's name, the legislature has demonstrated an awareness of the stigma attached to psychiatric treatment and the potential vulnerability of those seeking therapy.

**Individuals Protected**

The repealed statute extended the umbrella of confidentiality to encompass conversations with the patient's family members in furtherance of the patient's diagnosis or treatment. Evidently, this

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41. Section 2(7) of the Act states that the personal notes shall be considered part of the patient's record if the therapist does not keep sole possession of the notes or if they are disclosed to someone other than the therapist's supervisor, consulting therapist or attorney.  
_id_ § 2(7).
42. _Id._ § 3(b).
43. _Id._ § 2(7).
44. _Id._ § 3.
46. Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 2(1), 1978 Ill. Legis. Serv. 1510 (West) (to be codified at _ILL. REV. STAT._ ch. 91 1/2, § 801 _et seq._).
47. See note 17, _supra_, and accompanying text.
direct approach is not followed in the new Act as there is no explicit mention of the confidentiality of the family members' expressions. Instead, the Act defines confidential communication as a communication made by a patient or other person to a therapist, to others, or in the presence of others, during or in connection with providing mental health services to the patient.\footnote{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 2(1), 1978 Ill. Legis. Serv. 1510 (West) (to be codified at ILL. REV. STAT. ch. 91 1/2, § 801 et seq.).} Apparently, the legislature concluded that a pigeonhole attempt to list those communications which engender confidentiality, as the past psychiatrist-patient privilege had done, would only detract from the Act's effectiveness. Therefore, a functional definition has been provided which renders confidential communications from anyone when made in furtherance of the mental health care of the patient. The new Act enlarges the psychiatrist's available resources by allowing him to consult, under privilege, the patient's friend, neighbor, employer, fellow employee, family member\footnote{According to the repealed privilege, the psychiatrist was permitted to consult a family member for supplemental information without endangering the confidentiality of the treatment.} or anyone else who may be able to supply the desired information.\footnote{Professor Spector has asserted that the repealed psychiatrist-patient privilege had spread the umbrella of confidentiality to its fullest extent. Spector, Confidential Communication Privileges, 1971 REPORT OF THE ILLINOIS JUDICIAL CONFERENCE 117, 125. The Act, by broadly preserving confidentiality for communications made in contribution to the mental services, further enlarges this circle of confidentiality.} Additionally, the recent enactment continues to safeguard the confidentiality of the psychiatric environment where necessary persons\footnote{ILL. REV. STAT. ch. 51, § 5.2(1977) (repealed 1978). The specific enumeration of individuals who preserve the confidentiality under the repealed statute, such as persons under the supervision of the psychiatrist, is implicitly adopted by the Act.} are present and may have overheard the privileged communication.

**Purposeful Communication**

The requirement which still restricts the confidentiality of any communication is that the communication be made during or in connection with the providing of mental health or developmental disabilities services.\footnote{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, § 2(1), 1978 Ill. Legis. Serv. 1510 (West) (to be codified at ILL. REV. STAT. ch. 91 1/2, § 801 et seq.).} This parallels the previous statute which required the communication to relate to the diagnosis or treatment of the patient. However, the Act gives a broad, non-exhaustive definition of these services, which includes examination, diagnosis, evalu-
ation, treatment, training, pharmaceuticals, aftercare, habilitation, or rehabilitation. One commentator has submitted that requiring the communication to relate to diagnosis or treatment under the repealed statute was not a serious restriction because virtually every communication in psychiatry can be so interpreted. This argument applies a fortiori under the Act because of the expansive meaning given to mental health and developmental disabilities services.

**Legislative Definition of Therapist and Recipient**

Undoubtedly, the impact of the Act turns on the definition of therapist, because the therapist and the recipient are the principal figures in a confidential exchange. Consequently, the breadth or narrowness of the privilege is determined by the scope of the definition. The therapist under the Act specifically includes psychiatrist, physician, psychologist, social worker, or nurse, who provides mental health or developmental disabilities services. Prior to the Act, there was considerable question regarding whether a patient could invoke the psychiatrist-patient privilege when he had undergone psychiatric treatment with a professional other than a psychiatrist. The Act reflects a belief that patients who are treated for psychiatric matters should be entitled to the privilege, regardless of the title or occupation of the attendant. This logic is reasonable and practical in light of the increasing involvement of different professionals in the field of mental health. Although the occupation of the attendant may well determine the instruments and resources available for treatment, the different professionals share a common objective, improvement of the patient's mental condition. Moreover, each of the persons within the definition of "therapist" is trained in the practice of eliciting patient responses which require confidential treatment. Therefore, it seems equitable to entitle the patient to invoke the privilege regardless of which practitioner is performing the psychiatric services.

54. *Id.* § 2(3). Certainly, the broad definition ascribed to these services is partially explainable by the expansive occupational coverage given to the therapist in section 2(9) of the Act. *Id.* § 2(9). In short, the services reflect the different functions provided by the various professionals.

55. *Psychiatrist's Duty,* supra note 17, at 1115.


57. The repealed psychiatrist-patient privilege, Ill. Rev. Stat. ch. 51, § 5.2 (1977) (repealed 1978), expressly limited its coverage to one who is in fact a psychiatrist or a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry. Therefore, the privilege was ineffectual unless the attendant was a licensed physician or was reasonably believed to be so qualified.
The Illinois legislature has incorporated a clause in the Act which might preserve the confidentiality of a communication made to one who is not within the class of professionals defined as therapists. In addition to the designated professions, a therapist may be "any other person not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so." Although the wording is somewhat awkward and perplexing, the clause apparently requires two distinct conditions. First, it must not be illegal for the person to hold himself out as a therapist and it must not be a violation of law for him to provide such services; second, the patient must reasonably believe that the person can legally provide the mental health services. The definition would certainly preclude the use of the privilege for communications made to a voodoo specialist, but few instances can be so categorically rejected. One might contend, for instance, that a conversation with a religious leader or marriage counselor deserves the privilege provided by the Act. The argument would be strengthened if the person had actually performed the services and was not precluded by law from providing them. This determination of privileged status may evolve into a question regarding the reasonableness of the recipient's belief concerning the legality of the services and the precise nature of the services rendered. By requiring a finding of reasonableness, the legislature has made the court the final arbiter.

The definition of therapist under the Act appears to offer greater flexibility to the recipient than existed under the prior psychiatrist-patient privilege. Section 5.2 required the therapist to be "a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed by the patient to be so qualified." At a minimum, the patient must have reasonably believed that the attendant was a licensed physician. No such requirement inheres under the Act. Therefore, the reasonableness of the recipient's belief concerning the services to be rendered and the legality of those services must be the pivotal issue.

A court desiring to restrict the breadth of this open-ended clause


59. These individuals would not be within the scope of the repealed psychiatrist-patient privilege because the patient must reasonably believe that the person is a licensed medical practitioner. See note 57, supra.

defining the therapist may apply the principle of *ejusdem generis* to invalidate the privilege in a particular case. The court would use the rule in conjunction with the reasonableness of the claimant's belief. Essentially, the maxim of *ejusdem generis* requires that general words following an enumeration of specific persons or things must be limited to the same general kind or class as that specifically enumerated. Thus the marriage counselor or religious leader might be excluded from the privilege because these persons do not correspond to the same general classes of professionals which are designated under the therapist definition. The common denominator among the listed classes is specialization in the fields of medical science, psychology, or social work. Therefore, it would be reasonable for a court to demand a prerequisite showing that the purported therapist commands an expertise in these disciplines.

There is a further consideration which may prove significant in determining the scope of the therapist definition. An appellate court decision, construing the repealed psychiatrist-patient privilege, has required a showing of intention or expectation of confidentiality by the patient in order to sustain the privilege. This ruling should remain effective because it strikes at the foundation of privilege law, the expectation of confidentiality. The patient's difficulty in establishing an expectation of confidentiality may bear directly on the calling of the person to whom the communication was made and the purpose for which it was made.

**Holder of the Privilege**

The Act grants the right to assert the privilege to both the recipient and the therapist, thus perpetuating a fundamental characteristic which has distinguished the Illinois privilege from those in other states. Section 10(a) of the Act states that "a recipient,

63. See McCormick (2d ed.), supra note 11, § 72 at 151-52.
64. For example, a communication made to a psychiatrist in the course of a personnel screening program would initially appear to be privileged. Goldstein & Katz, supra note 20, at 186. The argument in favor of confidentiality would be supported by the fact that the psychiatrist is explicitly included within the definition of therapist. The claimant, however, must intend or expect confidentiality when he makes his disclosures and this would seem entirely unreasonable in light of the facts. The psychiatrist, in the example, is principally responsible to the employer and must inform the employer of the individual's mental health. A court could rightfully attribute knowledge of these facts to the claimant and therefore disallow the therapist-recipient privilege.
and a therapist on behalf and in the interest of a recipient, has the privilege to refuse to disclose and to prevent the disclosure of the recipient's record or communications." At least one virtue of granting this right to the therapist is that the professional could become the final protection for a patient who has inadvertently waived the privilege.  

A similar problem area remained unaddressed under the previous statute. It was debatable whether the psychiatrist could prevent disclosure when the patient had intentionally waived the privilege. If this situation occurs under the Act, "the court may require that the therapist, in an in camera hearing, establish that disclosure is not in the best interest of the recipient." The power to order such a hearing is reserved to the discretion of the court, although the provision is silent regarding other alternatives. The Act does not reveal whether the court could summarily rule in favor of either the therapist or recipient in the absence of the hearing. The answer may depend on the availability of other admissible evidence to sufficiently establish the propriety of disclosure.

The in camera hearing provision should considerably improve the recipient's confidentiality in the judicial proceedings. With no legislative restraint, courts under the prior privilege were free to assess the controversial disclosures in public courtrooms. Implementation of the in camera hearing when the therapist asserts the privilege over the patient's objection should temporarily limit disclosure to the individuals privy to the litigation. In the event the therapist asserts the privilege contrary to the wish of the recipient, the Act places the burden of justifying confidentiality on the therapist. To satisfy this burden, the therapist must cogently establish that disclosure is not in the recipient's best interests. The quantum of proof necessary to make this showing may depend on several factors. The court's willingness to tolerate infringement of the patient's right to determine disclosure may be

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66. Perhaps the classic example of inadvertent waiver is exemplified in Gottenmoller v. Gottenmoller, 37 Ill. App. 3d 689, 346 N.E.2d 393 (1976), where the plaintiff was held to have waived the privilege when she authorized a psychiatrist to furnish defendant's attorney with a copy of her psychiatric records.


68. Id. The Act is designed to protect the recipient's interest and expectation of confidentiality in the mental health services setting. It follows, therefore, that when the recipient has chosen to waive this right to confidentiality and the therapist insists on invoking the privilege on behalf of the recipient, it is incumbent upon the therapist to convincingly demonstrate the benefit to the recipient from his action.
of decisive importance. Furthermore, the ultimate decision may be influenced by the severity of the patient's mental condition. It is probable that the burden has been met when the patient cannot comprehend the consequences of disclosure, assuming that the therapist's actions can be reasonably construed to be in the best interest of the recipient. However, if the patient can establish that he is in control of his faculties and disclosure would not be particularly self-damaging, the therapist's burden to prevent disclosure may be insurmountable.

Absent Patient

Another pertinent issue concerns the patient's right to assert the privilege when he is absent from the forum at the time disclosure is sought. Proposed Illinois Rule 506 would have required that privileged matter not be admitted against a holder of the privilege unless there has been an opportunity to claim the privilege. However, in light of the Illinois Supreme Court's failure to adopt the rule, the matter is now left to the discretion of the courts. Without legislative guidance, the judge will be required to decide this critical issue predicated essentially on his perception of the equities. A ruling favoring admissibility could undermine the legislative goal of protecting the confidentiality of professional communication unless a compelling reason demands disclosures. Since the Act accentuates the importance of confidentiality, the patient's right to claim the privilege should not be subject to the whim of a particular tribunal when he is absent.

Exceptions To The Privilege

The intent of the Act is to afford sufficient protection to the patient, without jeopardizing important state interests. To accomplish this objective, the Act provides an expansive privilege, then carves numerous exceptions from that privilege when confidentiality must yield. The Act incorporates four broad exceptions from the previous psychiatrist-patient privilege and includes other fairly specialized exceptions. Analysis will be limited to those exceptions.

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69. Proposed Ill. R. Evid. 506 (Final Draft).
70. Proposed Ill. R. Evid. 506, intended to apply the all recognized privileges in Illinois, states that "Evidence of a statement or other disclosure of privileged matter is not admissible against the holder of the privilege if the disclosure was (a) compelled erroneously or (b) made without opportunity to claim the privilege." Id.
71. The Illinois Supreme Court, which appointed the committee to evaluate the Proposed Illinois Rules of Evidence, decided in February, 1979, to take no action on the rules.
72. See note 3, supra.
73. Those exceptions of the Act which find no parallel exception in the repealed
which have evolved from the prior statute and those innovative exceptions which should be invoked most frequently.

psychiatrist-patient statute and have therefore been excluded from the discussion are as follows:

Section 10.

(a) Except as provided herein, in any civil, criminal, administrative, or legislative proceeding, or in any proceeding preliminary thereto, a recipient, and a therapist on behalf and in the interest of a recipient, has the privilege to refuse to disclose and to prevent the disclosure of the recipient's record or communications.

(5) Records and communications may be disclosed in a proceeding under the Probate Act of 1975, approved August 7, 1975, as now or hereafter amended, to determine a recipient's competency or need for guardianship, provided that the disclosure is made only with respect to that issue.

(6) Records and communications may be disclosed when such are made during treatment which the recipient is ordered to undergo to render him fit to stand trial on a criminal charge, provided that the disclosure is made only with respect to the issue of fitness to stand trial.

(7) Records and communications of the recipient may be disclosed in any civil or administrative proceeding involving the validity of or benefits under a life, accident, health or disability insurance policy or certificate, or Health Care Service Plan Contract, insuring the recipient, but only if and to the extent that the recipient's mental condition, or treatment or services in connection therewith, is a material element of any claim or defense of any party, provided that information sought or disclosed shall not be redisclosed except in connection with the proceeding in which disclosure is made.

(8) Records or communications may be disclosed when such are relevant to a matter in issue in any action brought under this Act and proceedings preliminary thereto, provided that any information so disclosed shall not be utilized for any other purpose nor be redisclosed except in connection with such action or preliminary proceedings.

Section 12.

(a) If the United States Secret Service requests information from the Department of Mental Health and Developmental Disabilities relating to a specific recipient and the Director of the Department determines that disclosure of such information may be necessary to protect the life of a person under the protection of the Secret Service, only the following information may be disclosed: the recipient's name, address, and age and the date of any admission to or discharge from a Department facility.

(b) The Department of Mental Health and Developmental Disabilities and all private hospitals are required, as hereafter described in this subsection, to furnish the Department of Law Enforcement only such information as may be required for the sole purpose of determining whether an individual who may be or may have been a patient is disqualified because of that status from receiving or retaining a Firearm Owner’s Identification Card under subsection (e) of Section 8 of "An Act relating to the acquisition, possession and transfer of firearms and firearm ammunition", approved August 3, 1967, as amended.

Introducing One's Mental Condition

Section 10(a)(1) of the Act\(^74\) excludes from the privilege those communications made by a patient, who has introduced his mental condition or any aspect of services received for the condition as an element of his claim or defense. The rationale for this exception is that a person could otherwise rely on his mental condition and simultaneously deny his adversary pertinent information which might refute the claim or defense.\(^75\) By extending the exception to include "any aspect of his services received for such condition,"\(^76\) the Act resolves any doubt concerning the scope of this exception. In the past, the patient could presumably have introduced such matters as the effects of prescribed medical drugs without incurring forced disclosure of privileged material.\(^77\) Under the Act, this type of claim would undoubtedly fall within the exception.

Section 10(a)(1)\(^78\) is confined under the Act to civil and administrative proceedings. In omitting criminal proceedings from its coverage, this exception reflects the general belief that a criminal defendant should be entitled to greater evidentiary protection than a party to a civil or administrative matter.\(^79\)

Once the patient brings section 10(a)(1) into play by introducing his mental condition,\(^80\) the Act continues to protect the confidential-


\(^{77}\) This inference seems reasonable since the repealed privilege stated that introduction of one's mental condition rendered the privilege unavailable, but did not require a similar outcome when only "collateral" matters were involved.


\(^{79}\) Federal Rules, supra note 11, at 1330. This commentator has articulated the dilemma which would confront the individual if the exception were applicable to the criminal defendant:

Allowing the testimony of the psychotherapist of a defendant who raises an insanity defense to criminal charges is somewhat repugnant to the concept of privilege against self-incrimination. The idea that a defendant in a criminal case must choose between protecting his confidential communications or asserting an effective defense is unpalatable.

\(^{80}\) Testimony by the patient or his witness concerning the privileged communication will be deemed, under the Act, to be an affirmative introduction of one's mental condition. Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508,
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ity of the communication on record. This is accomplished by emphatically requiring the establishment of certain criteria before the exception can operate. The court must find, after in camera examination, that the evidence is relevant, probative, not unduly prejudicial or inflammatory, or otherwise clearly admissible. The court must also determine that other evidence is demonstrably unsatisfactory. Finally, in language echoing Wigmore's fourth criterion, the court must find that the interests of substantial justice sought to be achieved by disclosure are more compelling than the protection from injury to the therapist-recipient relationship achieved through the privilege. Again, the Act relies on the in camera procedure, which should ensure confidentiality while the court evaluates the evidence.

The enumeration of these mandatory considerations exemplifies the legislature's high regard for confidentiality in the field of mental health. This concern is expressed by the restrictions placed on the scope of disclosed material under the section 10(a)(1) exception. Upon satisfying the required criteria, disclosure is limited to the existence of treatment, the cost of services, and the ultimate diagnosis. This restriction can only be overridden when the trial court determines that there is a compelling need for the production of the communication, thus allowing disclosure of verbatim conversation.

A further restriction on the "Introducing the Mental State" exception has been incorporated in the Act. The Tylitzki doctrine

Art. I, § 10(a)(1), 1978 Ill. Legis. Serv. 1513 (West) (to be codified in Ill. Rev. Stat. ch. 91 1/2 § 810). Unlike the repealed statute, which had implicitly excluded the testimony of a witness on behalf of the recipient, the Act properly closes a gaping loophole to the exception.

81. Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, Art. I, § 10(a)(1), 1978 Ill. Legis. Serv. 1513 (West) (to be codified in Ill. Rev. Stat. ch. 91 1/2 § 810). The Act permits disclosure "if and only to the extent" that the enumerated considerations have been satisfied. Id.

82. Id.

83. See note 9, supra, and accompanying text.


85. The in camera hearing is recommended when the therapist asserts the privilege contrary to the express wish of the recipient. Id. § 10(b).

86. See notes 81-84, supra, and accompanying text.


88. Id.

89. Id.

states that a claim for pain and suffering shall not be deemed to be the introduction of one’s mental condition.\footnote{Id. at 149, 261 N.E.2d at 535-36. citing with approval Webb v. Quincy City Lines, Inc., 73 Ill. App. 2d 405, 219 N.E.2d 165 (1966).} According to the Tylitzki decision the psychiatrist-patient privilege is too important to be swept aside when the patient’s mental condition is no more than peripherally involved.\footnote{Tylitzki v. Triple X Serv., Inc., 126 Ill. App. 2d 144, 149, 261 N.E.2d 533, 536 (1970).}

**Limits of Disclosure After the Recipient’s Death**

Another exception retained but modified from the prior psychiatrist-patient privilege concerns disclosure after the recipient’s death. The privilege is waived when the recipient’s physical or mental condition has been introduced as an element of a claim or defense after the recipient’s death.\footnote{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, Art. I, § 10(a)(2), 1978 Ill. Legis. Serv. 1514 (West) (to be codified in ILL. REV. STAT. ch. 91 \(\frac{1}{2}\), § 810).} This introduction may be by any party claiming or defending through or as a beneficiary of the recipient. The modification is the extension to the introduction of physical condition, an element absent from the repealed statute. To ensure that the recipient’s confidentiality is not needlessly violated, this exception reiterates the required preconditions which govern disclosure under section 10(a)(1) of the Act.\footnote{See notes 82-84, supra, and accompanying text. The language of § 10(a)(1) of the Act, “not unduly prejudicial or inflammatory,” has been omitted from § 10(a)(2).} Thus, the Act withholds the privilege when a beneficiary under the recipient’s will or an heir of the recipient introduces the patient’s mental condition as an element of his claim.

Apparently, the introduction of evidence relating the recipient’s physical condition could also occasion disclosure of communications or records. At initial glance, it seems ironic that the involvement of the physical condition should precipitate disclosure of all mental health records. However, the Act deals with this potential inconsistency by conditioning this disclosure on a finding that the evidence is relevant, probative and that other satisfactory evidence is not available.\footnote{Mental Health and Developmental Disabilities Confidentiality Act, Pub. Act No. 80-1508, Art. I, § 10(a)(2), 1978 Ill. Legis. Serv. 1514 (West) (to be codified in ILL. REV. STAT. ch. 91 \(\frac{1}{2}\), § 810).} These considerations should obviate any potential abuse which this aspect of the Act might have produced.

**Recipient Against Therapist**

Section 10(a)(3) of the Act negates the privilege when a patient\footnote{This includes the patient’s beneficiary following his death. Id. 10(a)(3).}
proceeds against the therapist for injury caused in the course of providing mental health services. The need for the exception arises because the Act grants the privilege to the recipient and the therapist, even though the latter is intended to exercise the privilege on behalf of the recipient. Thus, this exception appears to have been enacted to ensure that the therapist is able to fully defend himself against civil suits. The Act permits the therapist and other persons challenged to disclose pertinent records and communications to an attorney engaged to render advice or to provide representation in the matter.

However, the Act leaves one aspect of this problem unresolved. When a patient sues the psychiatrist and wishes to present evidence concerning their confidential communication, it would seem possible for the psychiatrist to block disclosure by asserting his independent privilege. Yet, such an extension of the privilege seems unreasonable, as the privilege has been enacted to protect the confidentiality of the patient. Although the exception provides no direct guidance to resolve this apparent inconsistency, the Act addresses this conflict elsewhere. Section 10(b) declares that when the therapist asserts the privilege on behalf of a recipient, but contrary to the express wish of the recipient, the court may require the therapist to establish that disclosure is not in the best interest of the recipient. In order to effectuate the obvious intent of the legislature, the court should refuse the asserted privilege in a malpractice proceeding initiated by the recipient. This is warranted because the patient has chosen to divulge his confidences, thus rendering the legislative policy of protecting the patient inapplicable. Injustices would inure to a patient if his psychiatrist could routinely defeat these claims by invoking the privilege.

The Court-Appointed Therapist

According to section 10(a)(4) therapist-recipient communications are not privileged when made in the course of a court-ordered examination. This exception is conditioned on prior notice of non-

97. Id. 10(a).
98. See note 97, supra, and accompanying text.
100. The legislature seems to contemplate a protected “right” of the recipient to voluntarily waive the privilege evidenced by a difficult burden on the therapist when the latter asserts the privilege to bar disclosure contrary to the recipient’s wish.
101. Id. § 10(a)(4).
confidentiality being presented to the patient. In *People v. English*, the Illinois Supreme Court had indicated that a similar exception in the repealed privilege statute was unnecessary, because under the circumstances the patient did not consult the psychiatrist for the purpose of securing mental health services. The Act incorporates this exception in spite of the supreme court decision.

In an effort to safeguard the interests of the patient, two restrictions are imposed on the employment of this exception. First, the court must find that the recipient has been adequately and effectively informed regarding the non-confidentiality of the communication. Second, the discourse is admissible only regarding issues involving the recipient’s physical or mental condition, and then only to the extent that it is germane to the proceeding. The repealed statute did not specify precisely who must inform the patient that the communication was not confidential, but presumably any reliable source would have sufficed. Under the Act, the court must be convinced that the patient has been informed as adequately and effectively as possible, thus restricting the potential field of informants. This restriction is important because the psychiatric patient may not fully comprehend the degree of incrimination his revelations may cause.

The second limitation regarding confining disclosure to issues involving the recipient’s physical or mental condition, has generated considerable activity in Illinois courts. An example, where the Illinois Supreme Court had to determine whether to allow testimony by psychiatrists concerning a defendant’s incriminating statements is *People v. Williams*. The defendant, convicted of murder by the lower court, had undergone pre-trial examination by two psychiatrists in order to evaluate his competency to stand trial. The court

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102. *Id.*
103. 31 Ill. 2d 301, 201 N.E.2d 455 (1964).
106. *Id.*
107. *Federal Rules, supra* note 11, at 1329. In *People v. English*, 31 Ill. 2d 301, 201 N.E.2d 455 (1964), the Illinois Supreme Court held that the privilege against self-incrimination is entirely applicable in the court-ordered psychiatric examination. Therefore, the patient need not answer any questions which would incriminate him. Accord, *People v. Ehrler*, 114 Ill. App. 2d 171, 252 N.E.2d 227 (1969). By sufficiently informing the patient, the individual should be cautious to divulge only necessary information.
109. The psychiatrist had been appointed by the court under the competency hearing
affirmed the decision of the trial court which had permitted the psychiatrists to testify, but restricted the testimony to the issue of the defendant’s mental condition. The Act embodies the Williams restriction when it limits disclosure to matters involving the recipient’s mental or physical condition. The application of the Williams principle makes any statements admissible which contribute information concerning the physical or mental condition of the recipient, regardless of their incriminating nature. This can often cause extreme prejudice to the party involved, as under the Illinois Sexually Dangerous Persons Act.

Since good cause must be shown before subjecting the recipient to the court-ordered examination, the patient is protected from undue prejudice. A similar prerequisite was not incorporated in the repealed psychiatrist-patient privilege. This additional protection should preclude a court-ordered examination sought by a prosecutor or party on dubious criminal or civil charges, with the underlying hope of obtaining crucial admissions or other incriminating information. At a minimum, the requirement of good cause should focus the court’s attention on the basis for the examination, which on reconsideration may be found insufficient.

The Civil Commitment Exception

Section 11 of the Act preserves the civil commitment exception of the repealed statute and further provides three additional instances where disclosure may be justified. In addition to civil commitment proceedings, disclosure is permitted in accordance with provisions of the Abused and Neglected Child Reporting Act. Disclosure is also allowed when the therapist determines that disclo-
sure is necessary to initiate or continue civil commitment, or to protect the recipient or other person against imminent serious physical or mental injury, disease or death, or to protect the recipient from self-inflicted harm.116 Finally, disclosure is permitted when the therapist determines that disclosure is necessary for the provision of the emergency medical care to a recipient who is unable to assert his right to such care, where no relative or other third party is available to give consent.117

Prior to the Act, the provisions of the Abused and Neglected Child Reporting Act118 were grounds for disclosure of material otherwise protected by the physician-patient privilege,119 but not material protected by the psychiatrist-patient privilege.120 Several factors could explain the legislature’s incorporation of this additional exception into the Act. The general scheme of the Act is to treat various professionals on an equal basis, making exceptions applicable to all individuals.121 Furthermore, the legislature may have been unable to sufficiently justify the disparate treatment given physicians and psychiatrists. However, it is indeed possible that the exception has been included in the Act to further combat the increasing social problem regarding abused and neglected children.122

An attitude which pervades section 11 of the Act123 is the legislature’s deference to the competency, knowledge, and judgement of the therapist. Giving substance to this notion, the Act permits disclosure when the therapist, in his sole discretion, determines that it is necessary to initiate or continue civil commitment proceedings or to protect the recipient or another.124 The therapist’s sophisticated training should make him acutely aware of the symptoms which accompany suicidal, violent, or other types of dangerous behavior. Therefore, once the therapist has detected this behavior,

117. Id.
121. See notes 56 and 57, supra, and accompanying text.
124. Id. § 11(ii).
section 11 permits disclosure to the extent that it can be of benefit in preventing foreseeable harm to the recipient or another. The Act appears to support the use of the disclosure for any lawful means which the therapist may employ to avert imminent harm.\textsuperscript{125} This is a radical departure from the previous privilege statute, which restricted disclosure in these matters to civil commitment proceedings.\textsuperscript{126}

Section 11(iii) of the Act allows disclosure when, in the sole discretion of the therapist, it is necessary to provide emergency medical care\textsuperscript{127} to a recipient who is unable to assert his rights to such treatment.\textsuperscript{128} This power arises only when there is no other legally-qualified person available to give consent.\textsuperscript{129} The plain import of this exception is to make the preferences of the recipient regarding emergency medical care available to the necessary medical personnel. It may also help reveal those idiosyncrasies or sensitivities which would make particular medical treatment unadvisable. To the extent that disclosure can clarify the recipient's preferences or sensitivities, the therapist may release the information. The framing of the exception in terms of emergency medical care indicates that the legislature recognized the potential for abuse and sought to prohibit disclosure in instances of routine medical care.

\textit{Hospitalization Proceedings}

Commitment proceedings, which determine whether a patient must undergo involuntary hospitalization, necessitate a relaxation of the privilege.\textsuperscript{130} The hospitalization exception\textsuperscript{131} applies only to commitment proceedings, thus, the privilege resumes once a patient

\textsuperscript{125} This seems a likely inference because the exception permits disclosure when the therapist endeavors "to otherwise protect the recipient." \textit{Id.}

\textsuperscript{126} ILL. REV. STAT. ch. 51, § 5.2(a) (1977) (repealed 1978).

\textsuperscript{127} The Act, by adopting the language "emergency medical care," implicitly extends to treatment for physical and mental problems. Under the repealed statute, the only medically-related exception was for hospitalization.


\textsuperscript{129} Id.

\textsuperscript{130} Other states have relaxed the privilege in order to facilitate the commitment proceeding. See, e.g., CONN. GEN. ANN. § 52-146(f)(b) (West Supp. 1978); KY. REV. STAT. § 421.215(3)(a) (1972); N.M.R. EVID. 504(d)(1) (1977); TENN. CODE ANN. § 24-112(3) (Supp. 1978). See also FLA. STAT. ANN. § 90.033(4)(a) (West Supp. 1979) (psychotherapist privilege); ME. R. EVID. 504(e)(1) (West Supp. 1978) (physician and psychotherapist privilege).

is hospitalized. The state interest in properly and fairly arriving at an order of commitment necessitates setting aside the privilege in order to furnish a court with all relevant information. The patient's freedom depends on the outcome of this difficult decision-making process. The operation of the exception is most important in the case of a marginally disturbed individual. There, the previously unavailable testimony may enable a court to make a more informed determination in a case clearly lacking in absolutes.

Disclosure under the hospitalization exception will not always work to the detriment of the patient. If a frivolous or unsupported commitment suit has been brought against the patient, disclosure of the communication may persuade the court that the suit is unfounded.

The Act maintains further safeguards within the hospitalization exception. Although the commitment proceeding is a civil matter, the proponent must still establish his claim with convincing evidence. Furthermore, the Act restricts disclosure to the commitment proceeding itself. This contrasts with the repealed statute, which only confined the admissibility of the communications "to issues relating to the need for such hospitalization." Finally, disclosure under the Act is furnished to the State's Attorney, and the Act

132. Goldstein & Katz, supra note 20, at 186.

133. Such a situation is present under the Illinois Mental Health and Developmental Disabilities Code, which authorizes involuntary hospitalization under prescribed circumstances. Mental Health and Developmental Disabilities Code, Pub. Act No. 80-1414, 1978 Ill. Legis. Serv. 1009 (West) (to be codified in Ill. Rev. Stat. ch. 91 1/2, § 1-100 to 128). The Act provides the following grounds for commitment: involuntary commitment may be imposed for a person dangerous to himself or to others, as well as for one unable to cope with everyday problems and hazards or provide for his basic needs. Id. § 1-119. Without precise guidelines to follow, the court possesses considerable latitude when applying the Code's standard on a case-by-case basis. The breadth of the Code's provision, coupled with the hospitalization exception to the privilege, may operate to improperly commit patients.

134. See Psychiatrist's Duty, supra note 17, at 1113; Fleming & Maximov, The Patient or His Victim: The Therapist's Dilemma, 62 CAL. L. REV. 1025, 1039-40; Goldstein & Katz, supra note 20, at 188. These authors assert that the patient would often regret the infliction of serious harm in calmer periods and the patient's initiation of psychiatric treatment indicates he desires help in controlling his impulses. See also Arons, Working in the "Cuckoo's Nest": An Essay on Recent Changes in Mental Health Law and the Changing Role of Psychiatrists in Relation to Patient and Society, 9 U. TOLEDO L. REV. 73, 80 n.24 (1977).

135. The involuntary commitment proceeding has general standards which should move the court to dismiss unsubstantiated suits for commitment. See note 133, supra.


prohibits the State's Attorney from utilizing this information for any purpose other than the commitment proceeding. 139

The hospitalization exception presents some potentially adverse effects on the therapist-recipient relationship. The draftsmen of proposed federal rule 504, 140 which includes a similar hospitalization provision, justify the exception by asserting that damage to the professional relationship of the individual parties is unlikely since "control over disclosure is placed largely in the hands of a person in whom the patient has already manifested confidence." 141 To the extent this argument is satisfactory, the reasoning fails to deal with the possible discouragement of future relationships. 142 It is indeed possible that many patients will view the therapist's disclosure, even in these limited circumstances, as a betrayal of the professional confidence. 143 The Illinois legislature should recognize this risk. Nevertheless, with the potential for improper commitment decisions in mind, the hospitalization exception seems to be justified. In the long run, it would appear to act as an important safeguard to due process in commitment proceedings. 144

WAIVER

The doctrine of waiver, which according to the Illinois courts prohibits a holder of a privilege from relying on the privilege once he has made or directed the voluntary disclosure of the communication, 145 should apply with equal force and effect to the provisions

139. Id.
140. PROPOSED FED. R. EVID. 504 (psychotherapist-patient privilege) has been formally rejected by Congress.
142. See Federal Rules, supra note 11, at 1326.
143. Several commentators submit, on the other hand, that the patient may appreciate the therapist's efforts to control the patient's impulses. See note 134, supra.
144. One commentator favored the hospitalization exception, even after articulating the potential detrimental ramifications. The writer favors the exception "since the possible harm to society and the patient himself present significant dangers which warrant disclosure." Federal Rules, supra note 11, at 1328. In a related matter note that due process safeguards have been strengthened in the area of guardianship under the new Illinois Probate Act. See note 114, supra.
145. See, e.g., People v. Newberry, 53 Ill. 2d 228, 290 N.E.2d 592 (1972) (defendant, who called psychiatrist to testify and elicited answers which required substantial reiteration of defendant's communication, waived privilege); Gottemoller v. Gottemoller, 37 Ill. App. 3d 689, 346 N.E.2d 393 (1976) (privilege waived when plaintiff authorized psychiatrist to furnish defendant's attorney with a copy of her psychiatric records); People v. White, 131 Ill. App. 2d 652, 264 N.E.2d 228 (1970) (defendant waived privilege when he failed to object to testimonial disclosure); People v. Givans, 83 Ill. App. 2d 423, 228 N.E.2d 123 (1967) (defendant waived privilege when he called his own psychiatrist to testify, and could not prevent state's psychiatrist from testifying).
regarding the therapist-recipient privilege, the Act provides no specific exemption from the common law rules governing waiver of evidentiary privileges. The most common example of waiver is by consensual disclosure of the privileged information.\textsuperscript{146} This form of waiver is exemplified in \textit{Gottemoller v. Gottemoller},\textsuperscript{147} where the patient waived the privilege because she released her psychiatric record to the opposing party’s attorney.\textsuperscript{148} As a further requirement, Illinois courts have tacitly required a showing of substantial or significant disclosure before a finding of waiver.\textsuperscript{149} Similarly, in \textit{People v. White},\textsuperscript{150} the court held that the failure to object at trial to the disclosure of privileged communication would constitute waiver. In a related case, \textit{People v. Givans},\textsuperscript{151} the court found that a defendant had waived the psychiatrist-patient privilege once he had called his own psychiatrist to testify. Thus, the principle of waiver has been a fixture in the area of psychiatrist-patient privilege. Nothing in the Act should drastically affect that result.

\textbf{Conclusion}

The Act represents legislative progress in the protection of the rights of recipients. By broadening the scope of those professionals covered, the Act presents a unified, consistent approach to the privilege. The privilege is carved with numerous exceptions each reflecting an instance where confidentiality must give way to important state interests. The exceptions should operate equitably, if the standards and considerations embodied in the Act are adhered to by the courts. Whether the courts will be willing to accept the “spirit” of the Act is indeed another question. Much of the Act’s purpose could be circumvented if a great emphasis is placed on prior case law. To effectuate the intent of the Act it might be necessary to occasionally disregard a prior decision which adopted a contradictory interpretation of the psychiatrist-patient privilege. Application of the Act consistent with the legislative intent, albeit contrary to precedent under the previous statute, will be a positive step towards effective protection of extremely sensitive communications.

\textit{Robert Herst}

\textsuperscript{146} See, e.g., Gottemoller v. Gottemoller, 37 Ill. App. 3d 689, 346 N.E.2d 393 (1976).
\textsuperscript{147} \textit{Id.}
\textsuperscript{148} \textit{Id.} at 695-96, 346 N.E.2d at 397-98.
\textsuperscript{149} See note 145, supra.
\textsuperscript{150} 131 Ill. App. 2d 652, 264 N.E.2d 228 (1970).
\textsuperscript{151} 83 Ill. App. 2d 423, 228 N.E.2d 123 (1967); \textit{cf.} People v. Newberry, 53 Ill. 2d 228, 290 N.E.2d 592 (1972) (allowing psychiatrist’s testimony on the issue of guilt).