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Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers Comments

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Comments

UNDERPRIVILEGED COMMUNICATIONS: EXTENSION OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE TO PATIENTS OF PSYCHIATRIC SOCIAL WORKERS

The law of evidence in most jurisdictions contains a highly significant limitation: communications from a client who consults a private psychiatrist for treatment of mental or emotional illness are privileged, while similar communications from a client to a psychiatric social worker are not privileged. This state of affairs stems from the failure of most evidence codes to provide testimonial immunity for psychiatric social workers who, as the mainstay of the staffs of most public mental health facilities, are virtually the "poor man's psychiatrist."

This Comment analyzes some of the consequences that result from the failure to provide statutory privilege to psychiatric social workers and proposes a number of legal theories courts could use to create or extend the privilege. Section I discusses in detail some of the problems that denial of this privilege creates for both patients and psychiatric social workers. Section II examines the traditional test for determining whether a relationship merits the protection of privilege, and applies it to the psychiatric social worker-patient relationship. Section III advances an argument based on functional similarities between presently privileged professionals and psychiatric social workers. Section IV proposes an argument based on agency principles. Section V discusses the problem from an equal protection perspective, and Section VI proposes an argument based on equitable considerations.

I

THE NEED FOR A PRIVILEGE

The poor rely primarily upon public and charitable facilities for medical, dental, and psychiatric services.[1] Because of the severe shortage of psychologists and psychiatrists,[2] welfare departments and

1. Davidson, *Government's Role in the Economy: Implications for the Relief of Poverty*, 48 J. URBAN L. 1, 36 (1970).

2. COMMUNITY COLLEGE MENTAL HEALTH WORKER PROJECT, ROLES AND FUNCTIONS FOR DIFFERENT LEVELS OF MENTAL HEALTH WORKERS 1 (1969). Some figures will give an indication of the shortage. Over 500,000 school-age children suffer from serious mental illness; less than .5 percent receive adequate care. In a recent year, 40 percent of the qualified applicants of all ages who requested help at outpa-

most public mental health programs cannot provide a fully trained psychiatrist or clinical psychologist for every indigent patient requiring treatment for emotional or mental illness.[3] Yet the need for these services is acute. Mental illness ranks with heart disease and cancer as one of the nation's three greatest health problems.[4] And although the incidence of mental disorders is highest among low-income groups, they receive the least attention.[5]

In response to the great demand for services, mental health agencies have found it necessary to expand the size of their staffs. Since adequate numbers of psychiatrists and clinical psychologists are not available for such assignments, the new positions are frequently filled by psychiatric social workers,[6] particularly in government supported institutions, where the staffing problem is most severe.[7]

Psychiatric social workers are mental health professionals who have received advanced training in the behavioral sciences,[8] but who

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tient psychiatric clinics were put on waiting lists for a period exceeding one year. Weihofen, *Mental Health Services for the Poor*, 54 CALIF. L. REV. 920, 921 (1966) [hereinafter cited as Weihofen].

3. Wittman, *Utilization of Personnel with Various Levels of Training: Implications for Professional Development*, in TRENDS IN SOCIAL WORK 191 (Nat'l Ass'n of Soc. Workers 1966).

4. Weihofen, *supra* note 2, at 920.

5. B. BERELSON & G. STEINER, HUMAN BEHAVIOR: AN INVENTORY OF SCIENTIFIC FINDINGS 639 (1964).

6. By 1960 all states employed psychiatric social workers in mental health programs. U.S. DEP'T OF HEALTH EDUCATION AND WELFARE, HEALTH MANPOWER SOURCE BOOK—MEDICAL AND PSYCHIATRIC SOCIAL WORKERS 28 (1960). By 1967, psychiatric social workers in outpatient clinics were already working more hours per week than psychiatrists and clinical psychologists combined. NATIONAL INSTITUTE OF MENTAL HEALTH, DATA ON STAFF AND MAN-HOURS, OUTPATIENT PSYCHIATRIC CLINICS IN THE UNITED STATES 6-16 (1967).

7. More than 90 percent of all psychiatric social workers are employed by a state-supported facility. NATIONAL ASSOCIATION OF SOCIAL WORKERS, PSYCHIATRIC SOCIAL WORKERS AND MENTAL HEALTH 21 (1960) [hereinafter cited as NAT'L ASS'N OF SOCIAL WORKERS].

8. *Cf.* Calif. Personnel Bd., *Psychiatric Social Worker* 1 (1969) (job description) [hereinafter cited as Calif. Personnel Bd.]. The academic degree that most psychiatric social workers possess is a master's degree. Nationally, 80 percent of psychiatric social workers in public mental health programs have a master's degree or Ph.D. U.S. DEP'T OF HEALTH EDUCATION AND WELFARE, HEALTH MANPOWER SOURCE BOOK, MEDICAL AND PSYCHIATRIC SOCIAL WORKERS 42 (1960). A typical university curriculum for a student preparing for a career as a psychiatric social worker includes courses in the following subjects: developmental psychology; individual, family, and small group practice; psychodynamics and psychopathology; human development and pathology; medical and psychiatric casework; mental health and rehabilitation program planning. UNIVERSITY OF CALIFORNIA (BERKELEY), ANNOUNCEMENT OF THE SCHOOL OF SOCIAL WELFARE 19-22 (1972).

Although other social workers, such as intake workers or caseworkers, may at times deal with intimate and highly personal information, the need for a privilege for

lack the medical background of a psychiatrist. In many instances they perform the same functions as psychiatrists and psychologists.[9] Nevertheless, patients treated by psychiatric social workers do not enjoy the confidentiality privilege that applies to the psychiatrist-patient relationship.[10]

As almost all state legislatures have recognized in enacting statutory privileges for physicians and psychiatrists,[11] successful therapy

such communications is not as acute as that for communications to psychiatric social workers who work directly with emotionally disturbed patients. These other categories of social worker are not dealt with in this Comment.

9. Many writers describe the work of psychiatric social workers as psychotherapy. *E.g.* R. GRINKER, H. MACGREGOR, K. SELAN, A. KLEIN, & J. KOHRMAN, PSYCHIATRIC SOCIAL WORK 112-32 (1961); J. ALVES, CONFIDENTIALITY IN SOCIAL WORK 97 (1959) [hereinafter cited as ALVES]; *cf.* Calif. Personnel Bd., *supra* note 8, at 1-2. Psychiatric social workers and supervisors of social worker training programs state that the services performed by psychiatric social workers and the techniques utilized by them are indistinguishable from those of psychiatrists and clinical psychologists. *E.g.*, interview with Professor Robert Wasser, School of Social Welfare, University of California, in Berkeley, California, March 1, 1973 [hereinafter cited as Wasser]. In many respects, the question is one of semantics; some would limit the use of the word "psychotherapy" to characterize the work of a medically trained psychiatrist or clinical psychologist. Questions of semantics aside, four propositions are relatively undisputed:

(1) Psychiatric social workers work directly with patients in solving their mental and emotional problems. *Id.*; *see* note 7 *supra.*
(2) In doing so they delve into intimate personal material in a way that requires confidence in order for success to be possible. *Id.*; *see* note 12-16 *infra.*
(3) Their academic training involves extensive study in psychological theory and clinical techniques. *See* note 8 *supra.*
(4) Numerically, they constitute the most significant professional class employed in mental health centers, devoting more hours per week to caring for patients than psychiatrists and psychologists, particularly in clinics that deal with indigents. *See* note 6 *supra.*

10. Many state agencies that provide social services for the poor have adopted confidentiality regulations, sometimes spurred by the requirements of federal funding. Generally, these have failed to command much respect from the courts, which have felt free to ignore or circumvent them when the occasion demanded. *E.g.*, Bell v. Bankers Life & Cas. Co., 327 Ill. App. 321, 64 N.E.2d 204 (1945). For a discussion of the devices used by courts to evade confidentiality requirements that fell short of being full-fledged privilege statutes, see ALVES, *supra* note 9, at 78 *et seq.*; Lo Gatto, *Privileged Communication and the Social Worker,* 8 CATH. LAW. 5 (1962).

11. Statutes providing privilege to the therapist-patient relationship are summarized in Comment, *Privileged Communications: A Case By Case Approach,* 23 MAINE L. REV. 443, 448-50 (1971). Of the 50 states and District of Columbia, 12 lack a privilege for physicians. Psychiatrists ordinarily receive protection under physician statutes, although five states have a separate psychiatrist privilege. (Four of these five are among the 12 states which do not have a privilege for physicians generally.)

All but 15 states and the District of Columbia have a psychologist privilege. Four have statutes conferring privilege upon marriage counselors. One state (New York) provides privilege for certified social workers. California provides privilege for licensed clinical social workers, but not for psychiatric social workers in general.

For a summary of states which have privilege for other relationships, such as clergyman-penitent, see 8 J. WIGMORE, EVIDENCE §§ 2285-2396. (McNaughton rev. 1961).

requires a strong bond of confidentiality.[12] "The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams . . . his sins, and his shame."[13] Thus, any intimation that information disclosed to the psychotherapist might not be held in confidence can gravely threaten the therapeutic value of the counseling relationship.

> Most patients who undergo psychiatry know that complete candor will be expected of them, and that they cannot get help except on that condition . . . . It would be too much to expect them to [comply with this requirement] if they knew that all they say . . . may be revealed to the whole world.[14]

The threat to the therapeutic value of this relationship is especially great in the treatment of patients from low income groups. These patients tend to be more distrustful of authority figures than their wealthier counterparts.[15] As a result, they generally are more likely to resist psychotherapy,[16] having learned from bitter experience to be wary of official figures who profess to be anxious to "help" them.[17]

The absence of privilege not only jeopardizes the possibility of effective treatment for the patient; it can also deter others from seeking attention.[18] Already there have been numerous cases in which a social worker's testimony has led to criminal sanctions against his client.[19]

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12. *E.g.*, the Legislative Comment accompanying CAL. EVID. CODE § 1014 (West 1968) states:

> Psychoanalysis and psychotherapy are dependent upon the fullest revelation of the most intimate and embarrassing details of the patient's life . . . . Unless a patient . . . is assured that such information can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment . . . depend.

The Comment adds that the authors had heard reliable reports that patieuts had refused treatment because of doubts about confidentiality. The authors expressed concern that disturbed individuals, if untreated, might pose a threat to the safety of others. CAL. EVID. CODE § 1014, Legislative Comment (West 1968).

13. M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952).

14. *Id.*

15. R. WALD, LAW AND POVERTY: 1965, 6-46 (1965); Rosenheim, *Privilege, Confidentiality, and Juvenile Offenders*, 11 WAYNE L. REV. 660, 669 (1965) [hereinafter cited as Rosenheim].

16. *E.g.*, Weihofen, *supra* note 2, at 925: "Psychiatr[ic care may be] a status symbol in Hollywood, but it [is] . . . a disgrace in Watts . . . ."

17. *Cf.* Gorman, *Psychiatry and Public Policy*, 122 AM. J. OF PSYCHIATRY 55, 58 (1965).

18. *Cf.* Goldstein & Katz, *Psychiatrist-Patient Privilege: The G.A.P. Proposal and the Connecticut Statute*, 118 AM. J. PSYCHIATRY 733, 734 (1961) [hereinafter cited as Goldstein & Katz]; Noble, *Protecting the Public's Privacy in Computerized Health and Welfare Information Systems*, 16 SOCIAL WORK 35, 37 (1971) [hereinafter cited as Noble]. This deterrence phenomenon has been noted in judicial opinions, *e.g.*, Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955).

19. *See, e.g.*, State v. Plummer, 5 Conn. Cir. 35, 241 A.2d 198 (1967), a

As it becomes known that under certain circumstances the therapist can be compelled to divulge information revealed to him during therapy, prospective clients will become reluctant to seek professional help for mental and emotional problems.

A limitation on privileged communications also creates a significant strain for the psychotherapist who is called to the witness stand. The psychiatric social worker, like the psychiatrist and psychologist, owes allegiance to a professional code of ethics that stresses the importance of preserving the trust of his patients.[20] Requiring him publicly to breach a professional confidence places him in a cross-fire of conflicting demands. The courts demand disclosure while his professional values insist upon secrecy. As a result, when confidentiality has not been protected, mental health professionals called as witnesses have been known to refuse to testify,[21] to fabricate,[22] to have "memory lapses" on the witness stand,[23] or to keep two sets of records.[24]

The denial of privilege also affects the economics of national health care planning. In recent years, the soaring costs of health care have tended to place many forms of medical service beyond the reach

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prosecution for lascivious carriage brought on the basis of information provided by state welfare authorities to the police. Rappeport, *Psychiatrist-Patient Privilege,* 23 MD. L. REV. 39, 46 (1963), describes two unreported cases. In one, the court permitted out-of-state lawyers to view Maryland hospital records. As a result a mother lost custody of her children when the lawyer was able to produce a description in court of her deranged conduct, even though she was then well and saner than her husband, who got the children. In the other case, a minister had his confessions of a college-age love affair—thought to be at least in part fantasy—paraded before his parishioners.

These risks are duly noted by prospective patients. The California Law Revision Commission commented: "[We have] been advised that proper psychotherapy often is denied a patient solely because he will not talk freely to a psychotherapist for fear that the latter may be compelled in a criminal proceeding to reveal what he has been told." 1965 CAL. LAW REV. COMM'N. 195.

20. Mary Richmond, the founder of social work, wrote: "In the whole range of professional contacts there is no more confidential relation than that which exists between the social worker and the person or family receiving treatment." M. RICHMOND, WHAT IS SOCIAL CASE WORK 29 (1922). *See also* NATIONAL WELFARE ASSEMBLY, CONFIDENTIALITY IN SOCIAL SERVICE TO INDIVIDUALS 5, 40 (1958).

21. *In re* Lifschutz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970); Binder v. Ruvell, Civ. Docket No. 52C2535 (Circ. Ct. Cook County, Ill., June 24, 1952) (reprinted in 150 A.M.A.J. 1241 (1952)). *See* COMMSSIONERS ON REVISION OF THE STATUTES OF NEW YORK, 3 N.Y. REV. STAT. 737 (1836) (quoted in 8 J. WIGMORE, EVIDENCE § 2380 (a), at 829 (McNaughton rev. 1961) [hereinafter cited as 8 WIGMORE]; Slovenko, *Psychiatry and a Second Look at the Medical Privilege,* 6 WAYNE L. REV. 175, 196 (1960).

22. Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications,* 10 WAYNE L. REV. 609, 627-29 (1963). *See* note 23 *infra.*

23. Interview with psychiatric social worker section, Bayview Mental Health Center, San Francisco, California, on April 24, 1973.

24. *Id. Cf.* GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT No. 45 92, 96 (1960) [hereinafter cited as G.A.P.].

of growing numbers of middle- and low-income families.[25] To counter this trend, paramedical specialists, who perform limited functions formerly performed by physicians or psychiatrists, increasingly are being employed in many medical fields, including mental health.[26] Some of the nontherapeutic functions now performed by certain psychiatric social workers, such as preparation of preadmission diagnostic work-ups in a clinic or hospital,[27] are clearly paramedical in nature. Many of these paramedical functions require the psychiatric social worker to process information that should be held in confidence. Public acceptance of the psychiatric social worker will be imperiled, however, if a patient's communications with him cannot enjoy the same degree of legal protection as those with the psychiatrist or clinical psychologist. Without privilege, the psychiatric social worker will be regarded by his patients as a second-class practitioner, well-meaning and sincere, perhaps, but incapable of protecting their interests. Under such circumstances they will naturally be unable to place full confidence in him. To the extent that this results, the movement to make health care more widely available through utilization of paraprofessionals will be adversely affected.

A second, related development—the team approach to health care—is similarly jeopardized when psychiatric social workers are denied privilege. Mental health facilities, like those of other medical specialties, increasingly have been using an approach in which teams of specialists from many fields coordinate their expertise in the treatment of the patient.[28] This technique makes possible more efficient treatment and results in a higher standard of health care.[29] In many mental health clinics, these integrated teams include psychiatric social workers.[30] However, of all the team members—clinical psychologists, psy-

25. REPORT OF THE NAT'L ADVISORY COMM'N ON HEALTH MANPOWER 15-32 (1967); Gorman, *Psychiatry and Public Policy*, 122 AM. J. OF PSYCHIATRY 55, 57 (1965).

26. Forgotson, Roemer, and Newman, *Innovations in the Organization of Health Services: Inhibitive vs. Permissive Regulation*, 1967 WASH. U.L.Q. 400, 400-01 (1967). *See* U.S. DEP'T OF HEALTH EDUCATION AND WELFARE, HEALTH MANPOWER SOURCE BOOK 21—ALLIED HEALTH MANPOWER SUPPLY AND REQUIREMENTS: 1950-1980 at 9 (1970); NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR 22 (1967).

27. *See* A. FINK, C. ANDERSON, & M. CONOVER, THE FIELD OF SOCIAL WORK 235-37 (1968) [hereinafter cited as A. FINK]; CALIF. DEP'T OF MENTAL HYGIENE, PROFESSIONAL SOCIAL WORKERS IN MENTAL HEALTH PROGRAMS 4-71 [hereinafter cited as CALIF. DEP'T OF MENTAL HYGIENE].

28. Goldstein & Katz, *supra* note 18, at 736.

29. Judicial notice of this practice, acknowledging its positive effect on efficiency, was taken in Wyatt v. Stickney, 325 F. Supp. 781, 783 (M.D. Ala. 1971).

30. "Psychiatric social workers are a key group participating in every phase of the department's program—treatment, rehabilitation, training, [and] research . . . ." CALIF. DEP'T OF MENTAL HYGIENE, *supra* note 27, at 1.

chiatrists, physicians, and psychiatric social workers—only the social worker lacks privilege. This omission creates a weak link that effectively neutralizes the protection afforded communications to the other professionals; the nonprivileged social worker can become a conduit through which otherwise privileged information can flow.[31] This leak threatens the successful application of team treatment techniques.

Thus, it is evident that the failure to provide a statutory privilege[32] for communications to psychiatric social workers creates serious problems. The remainder of this Comment reviews the various legal grounds that can be used by the courts to extend the privilege to psychiatric social workers.

II

THE TRADITIONAL TEST FOR EXTENDING PRIVILEGE

Privilege is typically a matter of statutory creation.[33] On appropriate occasions, however, courts have been willing to create privileges in the absence of a statute.[34] Wigmore developed the classic test for determining when a relationship merits the protection of confidentiality:[35]

(1) The communication must have been imparted in confidence that it would not be disclosed to others.

(2) The preservation of secrecy must be essential to the success of the relationship.

(3) The relationship must be one that society wishes to foster and protect.

(4) Any injury to the relationship caused by disclosure must out-

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"As an active contributor to diagnostic procedures, planning, and treatment [the psychiatric social worker is] a professional partner of other specialists—psychiatrists, nonpsychiatric physicians, psychologists . . . ." *Id.* at 2.

"Within the clinic, the psychiatric social worker maintains direct contact with the other team members to insure close interdisciplinary communication." NAT'L ASS'N OF SOCIAL WORKERS, *supra* note 7, at 17.

31. *See* material cited note 19 *supra*. *Cf.* Lewis, *Confidentiality in the Community Mental Health Center*, 37 AM. J. ORTHOPSYCHIATRY 946, 948 (1967).

32. The problem can be readily solved by legislative action, and in the long run this would be the best solution. This could be accomplished by simply adding "or psychiatric social worker" to the statute providing privilege to psychotherapists. If greater narrowness is desired, the qualification, "when performing psychotherapy of a nonmedical nature," could be added. *See* CAL. EVID. CODE § 1010(c) (West Supp. 1973).

33. *E.g.*, CAL. EVID. CODE § 911 (West 1968). *Cf.* 8 WIGMORE, *supra* note 21, § 2286(2), at 532.

34. *E.g.*, Binder v. Ruvell, Civ. Docket No. 52C2535 (Circ. Ct. Cook County, Ill., June 24, 1952) (reprinted in 150 A.M.A.J. 1241 (1952)); *Re* Kryschuk and Zulynik, 14 D.L.R.2d 676, 677 (Police Magis. Ct., Sask. 1958).

35. 8 WIGMORE, *supra* note 21, § 2285, at 527.

weigh the expected benefit to be derived from compelling disclosure.

In jurisdictions lacking privilege statutes, courts have consistently referred to these criteria when deciding whether to grant or deny privilege in specific instances.[36] The test has been rigorously applied; in a majority of the cases, courts have held that the criteria, particularly the fourth, were not satisfied.[37] Of the handful of cases in which a privilege has been judicially extended in this manner, however, at least two involved members of the counseling and therapeutic professions.[38] And the commentators have concluded that therapy, when conducted by responsible, licensed professionals, is a relationship that satisfies Wigmore's criteria.[39]

In applying Wigmore's test to the relationship between a psychiatric social worker and his client, it is evident that all the requirements are met. Communications between a psychiatric social worker and his patients are imparted in the expectation of deepest confidence. The authorities agree that therapy requires complete candor of the patient, who must reveal compulsions, fantasies, fears, obsessions, and guilt feelings of such a private nature that he probably has never revealed them before, even to his closest friends.[40] No one would make revelations of this nature without the expectation that they would be held in confidence.

Also, preservation of confidentiality is essential to the success of the relationship. Without the security of a strong foundation of trust, the client will be unwilling, sometimes unable, to cooperate with his therapist in bringing to the surface painful repressed material, or in participating uninhibitedly in therapeutic measures designed to hasten his recovery.[41]

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36. *E.g.*, Falsone v. United States, 205 F.2d 734, 740 (5th Cir. 1953); State v. Smythe, 25 Wash. 2d 161, 168, 169 P.2d 706, 710 (1946).

37. *E.g.*, State v. Smythe, 25 Wash. 2d 161, 169-70, 169 P.2d 706, 711 (1946).

38. *See* cases cited note 34 *supra.*

39. *E.g.*, Louisell & Sinclair, *The Supreme Court of California 1969-1970, Foreword: Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective*, 59 CALIF. L. REV. 30, 52 (1971) [hereinafter cited as Louisell & Sinclair]; Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 184-99 (1960).

40. In fact, the success of a psychiatric social worker is often measured by the extent to which he obtains a flow of private thoughts and feelings. *Cf.* Dembitz, *Ferment and Experiment in New York: Juvenile Cases in the New Family Court*, 48 CORNELL L.Q. 499, 521 (1963).

41. *E.g.*, Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955): "In regard to meutal patients, the policy behind such [privilege] statutes 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 [psychotherapist] must have his patient's confidence or he cannot help him." *See also* notes 39 *supra* & 100 *infra.*

Moreover, successful therapy is so critically needed in our anxiety-ridden society that there can be little doubt that the injury that can result from disclosure outweighs the burden a privilege would impose on the courts' fact-finding machinery.[42] This conclusion has already been reached by the legislatures of a large majority of states which have granted the privilege to psychiatrists and psychologists.[43] When psychiatric social workers provide the same socially useful service as is now provided by these other professionals,[44] the state's failure to enact comparable legal protections for the benefit of their patients risks severe impairment of their ability to provide service.

One concern that might arise if the courts grant privilege to psychiatric social workers is that unqualified, self-appointed "therapists"—faith healers, meditators, and the like—might launch demands for recognition.[45] This does not present an insurmountable problem, however. In enacting privilege statutes legislatures have consistently distinguished between professions that have achieved some form of official state recognition or control,[46] such as through licensing laws or establishment of a state occupational category, and those that have not. Since most psychiatric social workers are employed in state facilities,[47] and are thus subject to state control and supervision, privilege could be provided for those psychiatric social workers but withheld from marginal groups which are not recognized or regulated by the state.

Consequently, on the basis of the four classic criteria, and with the understanding that privilege can be limited to recognized, licensed professionals, the courts should grant the privilege of confidentiality to psychiatric social workers.

III

Extension Based on Functional Similarities

Therapy is a clinical function. It can be performed by members of a number of professional groups—psychiatrists, clinical psycholo-

42. G.A.P. *supra* note 24, at 93, 95; *Louisell & Sinclair, supra* note 39, at 53. *See also* note 100 *infra.*

43. *See* note 11 *supra.*

44. *See* text accompanying note 9 *supra.*

45. Reportedly, the reason the drafters of the Uniform Rules of Evidence did not choose to extend privilege to "family counseling and that sort of thing" is that "we can not open the door . . . to uncontrolled groups." Comment, *Functional Overlap Between the Lawyer and Other Professionals,* 71 YALE L.J. 1226, 1241 n.99 (1962).

46. Geiser & Rheingold, *Psychology and the Legal Process: Testimonial Privileged Communications,* 19 AM. PSYCHOLOGIST, 831, 834-35 (1967) [hereinafter cited as Geiser & Rheingold]; 1964 CAL. LAW REV. COMM'N, 437-38; Louisell, *The Psychologist in Today's Legal World: Part II,* 41 MINN. L. REV. 731, 733-35 (1957).

47. *See* note 7 *supra.*

gists, and family physicians—who have the privilege of confidentiality in a majority of American jurisdictions.[48] Since it is the therapeutic function that the law of privilege is designed to protect, rather than any particular set of favored individuals, there is little justification for extending privileged status to these groups but not to psychiatric social workers, when the job specifications of the latter also include administering therapy to psychologically disturbed people.[49]

Functional considerations are not unknown to the law. Indeed, they figured prominently in the deliberations of at least one group charged with drafting legislation relating to medical privilege. When the revisers of the California Evidence Code extended the psychotherapist privilege, first to psychologists, then to licensed clinical social workers, they were influenced by the conviction that it would be illogical and invidious to provide privilege to one group but to deny it to another performing essentially the same function.[50]

A functional approach is not too technical to serve as a guide for judicial decision-making, nor need it burden the courts with a flood of litigation. On the contrary, courts have always been ready to look behind an individual's nominal title in order to determine whether the function he was actually performing warranted the protection of privilege. Courts have refused to permit a physician or attorney to invoke privilege when it was clear that he was not really performing medical or legal services. For example, courts have denied privilege to a lawyer who was in reality serving as a tax consultant or general business advisor.[51] On the other hand, courts have granted privilege when the function performed, while outside the normal range of a professional's duties, was nonetheless entitled to privilege on some other ground.[52]

An additional reason for extending privilege to patients of psychiatric social workers is the need, discussed earlier, to work toward a more rational system of manpower allocation in the field of public health.[53]

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48. *See* note 11 *supra*. Communications with clergymen, when acting as counselors, are also often privileged.

49. *See* notes 8, 9 *supra*.

50. Interview with Prof. Sho Sato, Professor of Law, University of California, past Vice Chairman, California Law Revision Commission, in Berkeley, California, Sept. 22, 1972.

51. Olender v. United States, 210 F.2d 795, 806 (9th Cir. 1954); R.C.A. v. Rowland Corp., 18 F.R.D. 440 (N.D. Ill. 1955); *In re* Fisher, 51 F.2d 424, 425 (S.D.N.Y. 1934).

52. Simrin v. Simrin, 233 Cal. App. 2d 90, 43 Cal. Rptr. 376 (2d Dist. 1965) involved a rabbi who performed marriage counseling. His work was held not to fall under the state's priest-penitent privilege statute, which limited coverage to confessions, but was nonetheless granted privileged status by virtue of its confidential nature as counseling. There was no statute providing privilege for counselors generally.

53. Recent thinking in this area urges that the health professions be viewed as a matrix in which duties and responsibilities are allocated on the basis of actual

Where psychiatric social workers are urgently needed to perform essential functions, courts should not hesitate to invoke the doctrine of functional identities in order to supply them with the legal safeguards necessary to perform those functions effectively. Failure to do so impedes the attainment of a rational delivery system for mental health care, one which maximizes the effectiveness of each practitioner by assigning duties in accordance with functional capacity rather than categorical title.

IV

AGENCY CONSIDERATIONS

Under conventional agency principles, communications directed to the assistant or agent of a physician are privileged to the extent they would have been had they been directed to the physician himself.[54] Thus, courts in many jurisdictions have expanded the privilege to encompass communications made to nurses and attendants when they work under the direction or supervision of a physician,[55] to medical interns when they take medical histories of patients,[56] and, in a slightly different context, to lay draft counselors when they perform counseling services in a center under the direction of a clergyman.[57]

Similarly, communications from patients to psychiatric social workers administering therapy under the direction of a supervisor covered by the privilege should also be privileged under this rule. Many psychiatric social workers interview patients and family members in order to help determine which patients are to be admitted to mental health facilities and which are ready to be discharged.[58] In doing so, they usually answer to the physician in charge of admitting and

capacity for performing specific tasks—measured by training, experience, and demonstrated capacity—rather than by possession of a nominal title. Forgotson, Bradley, & Ballenger, *Health Services for the Poor—the Manpower Problem: Innovations and the Law*, 1970 WISC. L. REV. 756, 767 [hereinafter cited as Forgotson, Bradley & Ballenger.]

54. *See* cases cited notes 55-56 *infra*. This rule finds support in the treatises, *e.g.*, 8 WIGMORE, *supra* note 21, at § 2382; model codes, *see* UNIFORM RULES OF EVIDENCE rule 27 (1953); MODEL CODE OF EVIDENCE rule 221(c) ii (1942); and the evidence codes of many states, *e.g.*, CAL. EVID. CODE § 1012 (West Supp. 1973).

55. State v. Bryant, 5 N.C. App. 21, 167 S.E.2d 841 (1969); Ostrowski v. Mockridge, 242 Minn. 265, 65 N.W.2d 185 (1954); Mississippi Power & Light Co. v. Jordan, 164 Miss. 174, 143 So. 483 (1932). *Contra*, Weis v. Weis, 147 Ohio St. 416, 72 N.E.2d 245 (1947).

56. Franklin Life Ins. Co. v. William J. Champion & Co., 353 F.2d 919 (6th Cir. 1965).

57. *In re* Grand Jury Subpoena for Gordon Verplank, 329 F. Supp. 433 (C.D. Cal. 1971).

58. CALIF. DEPT. OF MENTAL HYGIENE, *supra* note 27, at 1-4; Rosenheim, *supra* note 15, at 666.

discharging patients. Other psychiatric social workers work directly with patients in outpatient clinics, in consultation with a director who is a psychiatrist.[59] In both cases, communications received by the social worker should be privileged under the agency principle.[60] Of course, psychiatric social workers who practice independently would not receive privilege under this rule, and some social workers might qualify for privilege in connection with some of their duties but not others.

V

EQUAL PROTECTION

Denial of privilege to patients of psychiatric social workers may even attain constitutional dimension under the guarantee of equal protection. In general, courts have gone to great lengths to ensure that citizens receive fair and even-handed treatment from the government.[61] Although the scope of equal protection review has been limited to some extent by certain decisions,[62] recent Supreme Court opinions have reaffirmed the vitality of this important constitutional principle.[63]

A. Compelling State Interest

Patients who use community and welfare services for treatment of mental or emotional problems do so primarily because they are poor.[64] At these facilities they ordinarily find themselves directed to the care of a psychiatric social worker,[65] with the consequent threat of com-

59. A. FINK, *supra* note 27, at 235. The increased flexibility and range afforded by agency principles is something on which the high-powered but overworked modern physician increasingly has come to rely. Today's highly trained medical specialist would feel enormously handicapped if, in order to protect the legal rights of his patients, he found it necessary personally to take charge of all aspects of their care. *E.g.*, Eureka-Maryland Assur. Co. v. Gray, 121 F.2d 104 (D.C. Cir.), *cert. denied*, 314 U.S. 613 (1941). As was discussed earlier, delegation and the team approach have proven effective and efficient means of dealing with community health problems. Where psychiatric social workers play a vital role in the treatment of patients, they too are entitled to this protection.

60. In similar circumstances, hospital records compiled by staff members for use by the hospital's physicians were held to be confidential. O'Donnell v. O'Donnell, 142 Neb. 706, 712, 7 N.W.2d 647, 650 (1943).

61. *See* cases cited notes 69-73 *infra*.

62. *E.g.*, Dandridge v. Williams, 397 U.S. 471 (1970).

63. San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278 (1973).

64. *See* note 1 *supra* & note 67 *infra*. Indeed, the great majority of these treatment facilities apply a financial test in screening prospective patients. An applicant who can afford private treatment is not accepted; or, a sliding fee scale is used which favors the destitute and encourages those who can afford private treatment to go elsewhere. Wasser, *supra* note 7.

65. *See* notes 6 & 7 *supra*.

pelled disclosure. A patient who can afford to engage the services of a private psychiatrist or clinical psychologist, however, does not run the risk that the confidences he reveals will be divulged.[66] Thus, the ability to pay is the major determinant of the extent to which a patient in therapy receives assurance of confidential treatment.[67] A significant form of protection is linked to the financial status of the patient.[68]

Classifications based on wealth occupy a disfavored place in equal protection law[69] and have been struck down in such contexts as criminal justice,[70] sentencing procedure,[71] and the right to vote.[72] Recent state court cases have even applied equal protection scrutiny to medical practices that imposed a greater burden upon indigents than others.[73]

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66. *See* note 11 *supra.*

67. The financial test that is frequently required at public treatment centers, [*see* note 64 *supra*] insures a very close correspondence between the class of all indigent mental patients and those who receive treatment from psychiatric social workers. For a recent discussion of the requirement of a close "fit" or correlation between the classes affected, see San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1288-94 (1973).

In general, "[t]he kinds of care provided in psychiatric facilities is a function of the socio-economic level of the patient. The private psychiatrist is most likely to treat the most prosperous; state facilities, the working class." A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS: A COMPARATIVE STUDY 276-78 (1958). *See also* note 1 *supra.*

68. And, the loss of protection is absolute, rather than merely relative. *See* San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1288-92 (1973). Patients who cannot afford a very expensive commodity—private psychiatry —are denied the benefit of privilege while those who can are accorded the full protection of the law.

69. *E.g.*, San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278 (1973) and cases cited notes 70-72 *infra.* For a broad discussion of this doctrine, *see generally Developments in the Law—Equal Protection,* 82 HARV. L. REV. 1065, 1121-24 (1969) [hereinafter cited as *Developments in the Law*]; *cf.* Michelson, *The Supreme Court, 1968 Term—Foreword,* 83 HARV. L. REV. 7, 17 (1969).

70. Douglas v. California, 372 U.S. 353 (1963); Griffin v. United States, 351 U.S. 12 (1956).

71. Tate v. Short, 401 U.S. 395 (1971); Williams v. Illinois, 399 U.S. 235 (1970).

72. Harper v. Virginia Bd. of Elections, 383 U.S. 663 (1966).

73. In New York City v. Wyman, 66 Misc. 2d 402, 321 N.Y.S.2d 695 (Sup. Ct. N.Y Co. 1971), the court struck down a regulation that required indigent women on Medicare who desired an abortion to first prove that an abortion was medically indicated; other women not on Medicare were not required to prove this. The court held the requirement discriminatory in that it tended to deprive low-income women of an opportunity freely available to others. Although this case was subsequently reversed, 30 N.Y.2d 537, 330 N.Y.S.2d 385, 281 N.E.2d 180 (1972), the decision is reported in a memorandum opinion and the grounds for reversal are uncertain. Schulman v. New York City Health and Hospital Corp., 70 Misc. 1093, 335 N.Y.S.2d 343 (Sup. Ct. 1972), another recent case, arose out of a requirement by the health department that abortion certificates bear the name of the patient. Finding that the city had no compelling reason for the requirement, the court struck down the regulation as an invasion of the patient's right to privacy, a violation of her patient-physician

The Supreme Court recently discussed poverty as a suspect classification in *San Antonio Independent School District v. Rodriguez.*[74] The Court had before it a claim that Texas' scheme for raising revenues for school districts unconstitutionally discriminated against residents of poor districts. Although after lengthy consideration the Court decided that the Texas plan did not discriminate against the poor, it seemed to leave intact the principle that wealth may be a suspect classification.[75] After reviewing past cases involving indigency, the Court developed a twofold test.[76] First, it must appear that the classification singles out a clearly defined group that by reason of its impecunity is unable to pay for a valuable benefit. Second, as a result of the classification, the group must sustain absolute deprivation of a meaningful opportunity to enjoy the benefit.

Both requirements are met in the case of indigent patients of psychiatric social workers. The poor have no realistic access to private psychiatry;[77] and those who receive care at the hands of psychiatric social workers are denied the benefit of privilege.[78] Other traditional indicia of a suspect classification are also very much in evidence in the case of poor persons who suffer from mental illness. They are "saddled with disabilities," "politically powerless," in need of protection from an unconcerned majority,[79] and subject to community stigma.[80] Thus, legislative action that allocates health care benefits in a manner which discriminates against this class should be constitutionally suspect.

Moreover, the interests invaded when privilege is denied—privacy,[81] the right to equal treatment at trial,[82] and, perhaps, access to

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privilege, and a violation of equal protection inasmuch as it placed an extra burden of stigma on single and married women who obtained the operation. Thus, courts have already begun to recognize the principle advanced here—that unequal medical regulations that encroach on important personal rights may violate equal protection.

74. 93 S. Ct. 1278 (1973).

75. *Id.* at 1288-94; *see also id.* at 1311 (Stewart, J., concurring).

76. *Id.* at 1290.

77. *See* notes 1, 67 & 68 *supra.*

78. *See* note 11 *supra.*

79. 93 S. Ct. 1278, at 1294.

80. *Id.* at 1333-36 (Marshall, J., dissenting).

81. Griswold v. Connecticut, 381 U.S. 479 (1965), In *In re* Lifschutz, 2 Cal. 3d 415, 431-32, 85 Cal. Rptr. 829, 839, 467 P.2d 557, 567 (1970) the California Supreme Court, citing *Griswold,* warned of the potential for encroachment upon constitutionally protected rights of privacy by the compelled disclosure of confidential communications between the patient and his psychotherapist.

Where a privilege statute exists, it provides evidence of a public policy in favor of confidentiality. This makes obtaining a civil remedy for invasion of privacy easier for patients injured by out-of-court disclosures and thus helps guarantee that such disclosures will occur less often. Goldstein & Katz, *supra* note 18, at 734 n.4. *Cf.* Racine v. Morris, 201 N.Y. 240, 94 N.E. 864 (1911). The principle of *Racine*—that legislatively created duties may give rise to a private cause of action—has been fol-

lowed in cases involving medical disclosures, *e.g.*, Munzer v. Blaisdell, 183 Misc. 773, 49 N.Y.S.2d 915 (Sup. Ct. 1944), *aff'd* 269 App. Div. 970, 58 N.Y.S.2d 359 (1945). Out-of-court disclosures by medical personnel are more common than one might think. *See* Erickson & Gilbertson, *Case Records in the Mental Hospital,* in ON RECORD 391, 408-09 (S. Wheeler ed. 1969).

82. *See* cases cited notes 70 & 71 *supra*. *Cf.* Sau Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1288 (1972). It is established that courts will not tolerate wealth-based classifications that impose unequal burdens on the rich and the poor at trial. Yet this is precisely what occurs when the law permits testimony from the therapist of the poor while forbidding it from the therapist of the well-to-do. Without privilege, of course, many patients will confide very little in their therapist. The therapeutic encounter becomes a guarded, defensive transaction in which the patient gains little (unless the therapist deceives the patient as to the degree of protection provided, *see* Section VI *infra.*). Patieuts who through naiveté or desperation reveal damaging material to the therapist lose the opportunity at trial to stand on an equal footing with those who can obtain private treatment. The testimony of a therapist can be utterly devastating. Even where a party is ultimately successful in court, permitting his therapist to testify against his wishes can do great damage:

(1) Revelation in a public trial that an individual has undergone psychotherapy can be harmful in itself; recall the Sen. Eagleton affair during the 1972 presidential campaign. Many employers hestitate to hire persons with a history of mental illness, and on a social level, loss of friendships and community esteem can follow public revelation that a person has suffered episodes of mental or emotional derangement.

(2) The range of psychiatric testimony, like that of psychiatric inquiry, can be extremely broad.

> Current . . . practice defines mental illness as something that can have its roots in the patient's earliest years, show its signs throughout the course of his life, and invade almost every sector of his current activity. No segment of his past or present [is] beyoud the jurisdiction of psychiatric assessment . . . . While many kinds of organizations maintain records of their members, in almost all of these some . . . attributes can be included only indirectly, being officially irrelevant. But since [psychotherapists] have a legitimate claim to deal with the 'whole person,' they officially recognize no limits to what they consider relevant.

Ericson & Gilbertson, *supra* note 81 at 390. Thus the individual is subject to testimony that can range over great areas of his life.

(3) Not only does the psychiatric record consider the patient's whole life; it selects and chooses events in a way that ordinary records do not. Acts of deviancy challenge the observer to reassess the character of the people responsible for them. A friend is exposed as a homosexual; suddenly past events, chance remarks, and mannerisms begin to stand out; we begin to restructure our impression of the individual. A politiciau is shot; the next day the newspapers are full of accounts interpreting the background of the would-be assassin. A famous author commits suicide; in the public discussion that follows, a new person emerges. The psychiatric record essentially does the same thing—it "builds a case." The record "is not regularly used, however, to record occasions when the patient showed capacity to cope honorably and effectively with difficult life situations. Nor is the case record typically used to provide a rough average or sampling of [a patient's] past conduct. One of its purposes is to show the ways in which the patient is 'sick' . . . and this is done by extracting from his whole life course a list of those incidents that have or might have had symptomatic significance." *Id.* at 402-03. It is evident that the public revelation of this kind of selectively gathered and interpreted evidence, couched in impressive-sounding scientific terminology, has the capacity of causing the patient irremediable harm. That this risk is imposed on the indigent patients of public mental health facilities but not on the patients of private therapists constitutes an inequity of no small proportions.

medical care[83]—are fundamental.[84] This combination—discrimination on the basis of a suspect class, together with encroachment on fundamental personal interests—generally has failed to withstand constitutional scrutiny unless a compelling state interest can be shown.[85]

It is likely that whatever interests the state might advance to justify a privilege for communications to psychiatrists while withholding it from communications to psychiatric social workers would prove inadequate to support this differential treatment. State health and

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83. While the Supreme Court has never held that health care is a fundamental interest, it has implied that it would hold to be fundamental any commodity that is a prerequisite to the exercise of a fundamental interest, when denial means complete inability to exercise the interest, and when doing so would not open the floodgates. San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1298-99 (1973). In *Rodriguez* the Court found the nexus between education and certain constitutionally protected liberties to be insufficiently close to warrant invoking strict scrutiny; and it is conceivable that it might come to the same conclusion with respect to health care. However, the case for education was weakened by the relative character of the benefit provided and the imperfect correlation between financial status and the amount of funding made available to "poor" districts, factors that are not present here. *Id.* at 1288-94.

Arguing along lines similar to those suggested by the "nexus" theory, commentators have urged that health care be recognized as a fundamental right. *See, e.g.*, Bendich, *Privacy, Poverty, and the Constitution*, 54 CALIF. L. REV. 407, 420 (1966). Similarly, mental health is a prerequisite to the full exercise of virtually all our most cherished liberties. The right to marry, to vote, to participate in the political process—hope of fully enjoying any of these is denied to emotionally ill patients who cannot secure effective care. Thus, a national commission has urged that medical care be accorded the status of a civil right. NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR 17-37 (1966). Other legal commentaries on medical subjects agree, *e.g.*, Forgotson, Bradley, & Ballenger, *supra* note 53, at 767.

Other authorities believe that effective health care, if not an absolute right, is at least a conditional one: where the state has undertaken to offer treatment, it must accept responsibility for supplying the minimal conditions necessary for making the treatment reasonably effective. Professor David Louisell, a widely respected authority on medical privilege and confidential communications, believes that psychotherapy and privilege are so inseparable that one necessarily implies the other: "The patient's right of confidential communication to his psychodiagnostician . . . is a function of his right to obtain such services. If he has a right to obtain such services, he has a correlative right to the essential confidentiality of communication." Louisell, *The Psychotherapist in Today's Legal World*, 41 MINN. L. REV. 731, 744 (1957). A recent decision by a federal circuit court announced a right to adequate rehabilitation for mentally ill patients housed in state facilities. It found that the state, having assumed the responsibility of providing services, could not maintain patients in a state of limbo for long periods of time without providing effective treatment. The opinion spoke of a constitutional right to receive "such individual habilitation as [would] give each of [the patients] a realistic opportunity to lead a more useful and meaningful life . . . ." Wyatt v. Stickney, 344 F. Supp. 387, 390 (M.D. Ala. 1972).

84. For a discussion of the fundamental-interest doctrine, *see, e.g.*, Dunn v. Blumstein, 405 U.S. 330, 336-42 (1972); Shapiro v. Thompson, 394 U.S. 618, 629-31 (1969). *Cf. Developments in the Law, supra* note 69, at 1120-21.

85. *See generally Developments in the Law, supra* note 69, at 1124.

welfare administrators might urge, for example, that they should be free to compile and circulate reports concerning patients without the trouble and expense of ensuring confidential handling of the records of those undergoing therapy. A mere saving in administrative efficiency, however, has been held not to constitute a compelling state interest when essential personal freedoms were at stake.[86] And, as a practical matter, this suggestion makes little sense since the relatively slight administrative gain is clearly outweighed by the potential damage to the entire therapeutic program that could result from one or two well-publicized exposures.[87]

Alternatively, the state might allege that it is necessary to treat as nonconfidential mental health data gathered from public treatment centers in order to facilitate research into the causes and conditions of mental illness, delinquency, and marital discord. This interest, however, could be served by a narrowly drawn research clause,[88] permitting the state to carry out research without forfeiting the substantial benefits of privilege, particularly that of protection against disclosure in court. In addition, most, if not all, legitimate research purposes can be served by supplying data in anonymous form, or, where individualized data are essential, by the use of coded records.[89]

Another possible state interest is protection of the state fisc. It could be argued that in order to remove violators from the welfare rolls, social workers must be able to report violations of eligibility rules when these come to their attention during therapy. Protection of the state fisc, however, has likewise failed to prevail in cases involving fundamental personal rights.[90] Moreover, withholding the confidentiality privilege is not necessary to protect the state's interest; other, more effective, means are available for discovering and verifying eligibility violations than depending on leads developed in the course of therapy.[91] Thus, while the interest might have some legitimacy when applied to ordinary caseworkers or intake workers,[92] its importance is

86. Shapiro v. Thompson, 394 U.S. 618 (1969). When deprivation of an important right is threatened, the state must be ready to bear the burden of a less onerous but higher-cost alternative. Carrington v. Rash, 380 U.S. 89, 95 (1965).

87. Goldstein & Katz, *supra* note 18, at 733; note 19 *supra*.

88. *See, e.g.*, CAL. EVID. CODE § 1011 (West 1968). *Cf.* Griffin v. Medical Soc'y, 7 Misc. 2d 549, 11 N.Y.S.2d 109 (Sup. Ct. 1939). For an exposition of the "less onerous alternative" doctrine, *see, e.g.*, Shelton v. Tucker, 364 U.S. 479 (1960).

89. A. MILLER, THE ASSAULT ON PRIVACY 239-57 (1971). California, for example, has instituted a number of such measures designed to protect the privacy of research subjects. *See* Noble, *supra* note 18, at 38-39.

90. Shapiro v. Thompson, 394 U.S. 618 (1969); Douglas v. California, 372 U.S. 353 (1963).

91. For example, home visits, periodic use of questionnaires, and cross-checking with the I.R.S. and other agencies are possible alternatives.

92. *See* note 8 *supra*.

outweighed by countervailing interests in the case of psychiatric social workers.

A further state interest, discussed earlier,[93] is the desire to discourage the practice of psychotherapy by charlatans and well-meaning but unqualified amateurs. It could be argued that extending privilege to an additional class makes it more difficult to resist subsequent claims by new groups for privileged status. As was observed, however, this purpose can be served by drawing the line to include only groups whose legitimacy has received state recognition through licensing statutes or the establishment of a state job category.[94] With state control and supervision the danger of quackery would be minimal, and a ready means for resisting premature claims by new groups would be available.

Given the impressive array of reasons favoring extension of the privilege to patients of psychiatric social workers, the relative insubstantiality of the interests the state seeks to protect, and the manner in which the statutory scheme discriminates against a suspect class, it is unlikely that the state will be able to satisfy the compelling interest standard required to justify the inequity currently perpetrated by most privilege statutes.

B. The Rationality Test

Even if the courts do not apply the compelling interest standard of equal protection review, however, withholding the privilege of confidentiality from patients of psychiatric social workers probably cannot survive under the less stringent rational basis test.[95]

Under the rational basis standard, legitimate reform measures need not solve every aspect of a problem.[96] Nor is a statute void if it might possibly fail to achieve its desired effect.[97] Nevertheless, a claim that a classification is rational may be defeated by showing that the classification cannot further the purpose underlying the legislation.[98]

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93. *See* text accompanying notes 45-47 *supra.*

94. *Id.*

95. *I.e.*, a reasonable relationship must exist between the purpose of the legislation and the classification provided by the statute. *E.g.*, Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920).

96. San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1299-1300 (1973); Dandridge v. Williams, 397 U.S. 471, 485-86 (1970).

97. Roschen v. Ward, 279 U.S. 337, 339 (1929).

98. *E.g.*, Police Dept. of the City of Chicago v. Mosley, 408 U.S. 92, 95 (1972); Weber v. Aetna Cas. & Ins. Co., 406 U.S. 164, 172 (1972); Eisenstadt v. Baird, 405 U.S. 438, 453-55 (1972); Morey v. Doud, 354 U.S. 457, 467-68 (1957). *See Developments in the Law—Equal Protection, supra* note 69, at 1083. *Cf.* Comment, *Legislative Purpose, Rationality, and Equal Protection,* 82 YALE L.J. 123, 151-54 (1972) for an excellent discussion of legislatively mandated goals.

Thus the limitation on the therapist-patient privilege could be found irrational, since the failure to recognize a psychiatric social worker-patient privilege is inconsistent with the policies behind the therapy privilege statutes[99] and legislation establishing mental health programs for the poor. The purpose of privilege statutes is to facilitate success in treatment.[100] Since medical authorities universally recognize that breaching a patient's confidence virtually eliminates any hope of improving his condition through therapy,[101] any measure that requires the disclosure of confidential communications for the sake of efficiency or some other extrinsic value jeopardizes the entire therapeutic program.

Moreover, extending a greater degree of protection to private patients than to indigents not only fails to achieve the legislative goals, it is invidious as well. One common definition of a rational classification is "one which includes all persons who are similarly situated with respect to the purpose of the law."[102] If privilege statutes exist in order to encourage the free flow of thoughts and feelings essential for the therapeutic relationship,[103] there is no rational justification for assuming that this need is less in the case of indigent patients. On the contrary, it is generally recognized that the need for trust and confidence is greatest in dealing with the poor.[104]

Thus, the classification suffers from lack of rationality in two key respects. It fails to promote its legislative objective and it draws a distinction between the wealthy and the poor that is arbitrary and counterproductive.

VI

EQUITABLE CONSIDERATIONS: REASONABLE BELIEF AND PRIVILEGE BY ESTOPPEL

The government owes a duty to those in its care to ensure that

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99. *See* text accompanying notes 12-14 *supra*.

100. *E.g.*, C. MCCORMICK, EVIDENCE 213 (2d ed. E. Cleary ed. 1972) states this as the rule with respect to physicians generally. As to psychotherapy:

> Although it is recognized that the granting of a privilege may operate in particular cases to withhold relevant information, the interests of society will be better served if psychiatrists are able to assure patients that their confidences will be protected.

CAL. EVID. CODE § 1014, at 232, *Legisl. Comment* (West 1968). Accordingly, many states have enacted statutes providing privilege to many professions whose members perform a similar function, *e.g.*, psychiatrists, psychologists, clergymen, and school counselors. *See* note 11 *supra*. The state's interest in providing effective mental health treatment is also evident from its huge investment in personnel and physical facilities. *See* notes 4-6 *supra* and accompanying text.

101. *See* notes 12-14 *supra*.

102. Tussman & tenBroek, *The Equal Protection of the Laws*, 37 CALIF. L. REV. 341, 346 (1949).

103. *See* text accompanying note 13 *supra*.

104. *See* notes 15-17 *supra*.

their constitutional rights are not violated as a result of the intimidating disparity between their own power and that of their governmental custodians.[105] The state must take particular care when it is dealing with persons who by reason of their poverty, lack of education, and unfamiliarity with bureaucratic structures cannot be expected effectively to understand and protect their own interests.

Poor people are ordinarily not familiar with the subtle differences among psychiatrists, clinical psychologists, licensed clinical social workers, and psychiatric social workers.[106]

The state job specifications of psychiatric social workers set out duties[107] that cannot be carried out successfully without first establishing a confidential relationship with the client. Indeed, psychiatric social workers are required by their professional code to provide an atmosphere of trust.[108] Thus, it is inevitable that many patients of state-employed psychiatric social workers will receive the impression, from nonverbal clues and suggestions if not from overt assurances,[109] that their communications will be held in confidence. When state agencies hire psychiatric social workers knowing of their professional commitment to confidentiality, and when they assign them duties which require such confidentiality to be performed successfully,[110] the state must assume a share of responsibility for fostering in the minds of many unsophisticated patients the belief that communications to the therapist will remain private.

Given the state's responsibility for creating this impression, it would be inconsistent and inequitable for the state to assert, in a criminal proceeding, for example, that privilege does not exist.[111] Accordingly, even if patients of psychiatric social workers cannot claim privilege as a matter of right, courts should invoke their broad equitable powers and refuse to countenance such assertions.[112]

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105. *E.g.*, Miranda v. Arizona, 384 U.S. 436, 457-72 (1966).

106. These categories may be meaningful to the well-educated clientele of private psychotherapists, but their implications are not readily perceived and appreciated by the poor and the ill-educated. Consequently, they are frequently unaware of the differences these distinctions entail with respect to their rights under the law of evidence. Interview with Bernard Diamond, Psychiatrist, Professor of Law and Criminology, University of California, in Berkeley, California, January 4, 1973.

107. *See* notes 8, 9 *supra*.

108. *See* note 20 *supra*.

109. The social worker often expressly assures the patient that his communications will be held in confidence. J. ALVES, *supra* note 9, at 92. Even without overt assurances, many patients will assume that their communications will be held confidential. Geiser & Rheingold, *supra* note 46, at 836.

110. *See* text accompanying notes 12-17 *supra*.

111. *Cf.* Smart v. Kansas City, 208 Mo. 162, 105 S.W. 709 (1907).

112. At one time, it was widely believed that the government could not be estopped by acts of its agents. *See, e.g.*, Federal Crop Insurance Corp. v. Merrill, 332

The importance of protecting patients' legitimate expectations of privacy has been acknowledged by a number of jurisdictions. In these states, statutory provisions afford privilege to persons who, though technically not entitled to privilege, reasonably believed they were consulting an authorized medical practitioner. For example, the California Evidence Code provides for protection of persons who consult an individual reasonably believed to be a psychiatrist or physician.[113] Voluminous case law from many jurisdictions supports this rule,[114] as do many of the model codes.[115] Thus, whenever patients are led to believe that the person with whom they are dealing is a psychiatrist, they should be able to claim privilege when their mistake is a reasonable inference from the circumstances or manner in which they are treated.[116]

CONCLUSION

Many writers oppose the creation of new privileges on the ground that they inhibit the ability of courts to ascertain the truth.[117] Truth,

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U.S. 380 (1947). In all likelihood the former reluctance of courts to consider estoppel against the government rested on an unstated belief that the state treasury should not be bled in order to redeem an erroneous promise extended by a public official. In the present situation, though, financial considerations are not especially prominent; the government suffers little financial harm if it should decide to honor the expectations of privacy developed by indigent patients as a result of the therapeutic encounter. A further ground of distinction lies in the fact that in *Merrill* the government's agent acted "wrongly" toward both the government, in misrepresenting its position, and toward the farmer, in inducing him to rely on nonexistent forms of protection. Here, however, it is the government that has acted wrongly toward both parties. It has furnished a situation in which the patient is deluded into believing that he will be dealt with confidentially. And it has placed the social worker in the position of having to represent that he can provide the patient with a security that in actuality he cannot guarantee. Thus the equities in both respects—financial cost and fair play—lie more strongly in favor of estoppel here than they did in *Merrill*. In similar situations, modern courts have upheld claims of estoppel when the necessary elements of deception and detriment were present. They have been particularly sympathetic to claims in which public officers have acted, as they have here, in the exercise of a power or duty expressly conferred upon them by statute. *E.g.*, United States v. Certain Parcels of Land, 131 F. Supp. 65, 74 (S.D. Cal. 1955) and cases cited therein.

113. CAL. EVID. CODE § 1010 (West Supp. 1973). Other states have similar provisions, *e.g.*, ILL. REV. STAT. ch. 51 § 5.2 (West Supp. 1973).

114. *E.g.*, People v. Decina, 2 N.Y.2d 133, 138 N.E.2d 799, 157 N.Y.S.2d 558 (1956); Ballard v. Yellow Cab Co., 20 Wash. 2d 67, 145 P.2d 1019 (1944); People v. Barker, 60 Mich. 277, 27 N.W. 539 (1886).

115. UNIFORM RULES OF EVIDENCE rule 27 (1953); MODEL CODE OF EVIDENCE rule 220(b) (1942).

116. Seemingly, these statutes would only protect a patient who believed that his therapist was a psychiatrist, *i.e.*, cases where the patient's error is a mistake of fact. Mistakes of law, where the patient knows his therapist is a psychiatric social worker but thinks psychiatric social workers have privilege, would fall outside this rule, although there seems to be no reason in logic or policy for this distinction.

117. *E.g.*, C. MCCORMICK, EVIDENCE 159 (2d ed. E. Cleary ed. 1972).

however, may be pursued at too great a cost.[118] The recent growth in the number of legislatively created privileges reflects society's belief that certain relationships are so important that they must remain inviolate even in the face of demands by the judicial system.

The relationship between a psychiatric social worker and his patient, while currently unprotected by legislation, is such a relationship. It is in the best interest of society that it be protected. Legislatures should act in this critical area. Until they do, existing legal doctrines may be used to provide remedies where they are needed.

Richard Delgado

118. Pearse v. Morse, 1 De G. & Sm. 28-29, 16 L.J. Ch. 153 (1846).