82-294

STATE OF MINNESOTA
IN SUPREME COURT

State of Minnesota,

Plaintiff/Respondent

vs.

David Gerald Andring,

Defendant/Appellant

BRIEF OF AMICUS
Minnesota Medical Association, and
Minnesota Psychiatric Society

KATHLEEN A. MEYERLE
Attorney for Amicus Curiae

Suite 400, Health Associations Center
2221 University Avenue S.E.
Minneapolis, Minnesota 55414
Telephone: (612) 378-1875

WARREN R. SPANNAUS
Minnesota State Attorney General
Second Floor, Ford Building
117 University Avenue
St. Paul, Minnesota 55155

ROBERT W. KELLY
Washington County Attorney

By: WM. F. KLUMPP, JR.
Asst. Washington County Attorney

Washington County Courthouse
Stillwater, Minnesota 55082

ATTORNEYS FOR RESPONDENT

C. PAUL JONES
Minnesota State Public Defender

By: MARGARET G. LaMARCHE
Assistant State Public Defender

95 Law Center
University of Minnesota
Minneapolis, Minnesota 55455

ATTORNEYS FOR APPELLANT

TABLE OF CONTENTS

Page

Interests of Amici Curiae.................................1

Legal Issues..2

Statement of Facts..3

Argument..3

I. PATIENTS PARTICIPATING IN GROUP THERAPY SESSIONS ARE REASONABLY NECESSARY FOR THE ACCOMPLISHMENT OF THE PURPOSE OF GROUP THERAPY AND AS SUCH COMMUNICATIONS ARE MADE TO THEM, ARE PRIVILEGED COMMUNICATIONS UNDER MINN. STAT. §595.02(4) 3

II. THE PHYSICIAN-PATIENT PRIVILEGE IN MINN. STAT. §595.02(4) SHOULD BE WAIVED WHEN PUBLIC POLICY DICTATES ONLY TO THE EXTENT NECESSARY TO PROVIDE A FOUNDATION FOR INVESTIGATION AND NOT TO COMPEL THE PHYSICIAN TO TESTIFY AGAINST A PATIENT/DEFENDANT INTEREST IN AVOIDING SELF-INCRIMINATION..........14

Conclusion..19

TABLE OF AUTHORITIES

Page

Minnesota Statutes

Minn. Stat. § 595.02....................................15
Minn. Stat. § 596.02(4)..............................3,5,14
Minn. Stat. § 626.556...................................15
Minn. Stat. § 626.556(1)................................14
Minn. Stat. § 626.556(3)................................15
Minn. Stat. § 626.556(4)................................15
Minn. Stat. § 626.556(8)................................3

Foreign Statutes

D.C. Code Ann. § 2-1704.16..............................8
Ill. Ann. Stat. ch. 911/2, § 810........................8
R.I. Gen. Laws, § 5-37.3-4..............................8
Tex. Rev. Cir. Stat. Ann. art. 5561h....................8

Cases

Minnesota Decisions

State v. Murphy, Fin. & Com. 37:7-9, Sept. 17, 1982,.......18
Case no. 82-271.
State v. Staat, 291 Minn. 394, 192 N.W. 2d 192 (1971)....5,17
Wenniger v. Muesing, 307 Minn. 405, 240 N.W. 2d 333.........9
(1976)

United States Decisions

Doe v. Bolton, 410 U.S. 179 (1973).........................10
Roe v. Ingraham, 480 F.2d 102, 108 n. 8 (2d Cir. 1973).....10
Poe v. Ullman, 367 U.S. 497 (1961).........................10
Roe v. Wade, 410 U.S. 113 (1973)...........................10

Foreign Decisions

In re Lifschutz, 2 Cal. 3d r15, 467 P. 2d 557,...........9,11
85 Cal. Rptr. 829 (1970)

Secondary Authorities

American Group Psychotherapy Association Defining...........4
Boundaries Task Force (1977).
American Medical Association, "Current Opinions.........2,11
of the Judicial Council," (1982).

American Medical Association Principles of Medical Ethics (1982). 2,11

American Psychiatric Association Model Law on Confidentiality of Health and Social Service Records 8,15

American Psychiatric Association, "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry," (1978) 2,11,12

Gumper, L.L., and Sprenkle, D.H., Privileged Communication in Therapy: Special Problems for the Family and Couples Therapist, Fam. Process, Vol. 20, No. 1, pp. 11-23, March, 1981. 7

Margolin, G., Ethical and Legal Considerations in Marital and Family Therapy, Am. Psychol., Vol. 37, No. 7, pp. 788-801, July, 1982. 7

Meissner, W.W., Threats to Confidentiality, Psych. Annals, Vol. 9, pp. 54-71, 1979. 6

Meyer, R.G. and Smith, S.R., A Crisis in Group Therapy, Am. Psychol., Vol. 32, No. 8, pp. 638-43, August, 1977. 7,12

Perr, I.N., Doctor-Patient Confidentiality: Suggested Legal Protections, Bull. Am. Acad. Psychiatry and the Law, Vol. 7, No. 3, pp. iv-viii, 1979. 17

Perr, I.N., Privilege, Confidentiality, and Patient Privacy: Status 1980, J. Forensic Sciences, Vol. 26, No. 1, pp. 109-115, January, 1981. 17

Redlich, F. and Mollica, R.F., Overview: Ethical Issues in Contemporary Psychiatry, Am. J. Psychiatry, Vol. 133, pp. 125-136, 1976. 6

Sadoff, R.L., Informed Consent, Confidentiality and Privilege in Psychiatry: Practical Applications, Bull. Am. Acad. Psychiatry and the Law, Vol. 2, pp. 101-106, 1974. 6

Saltzburg, S.A., Privileged Professionals: Lawyers and Psychiatrists, 66 Va. L. Rev., 597-650, at 617-619, April, 1980. 7

Shuman, D.W. and Weiner, M.S., The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege, 60 N.C.L., Rev. 893-942 at 907, June, 1982. 8,13

Slovenko, R., Group Psychotherapy: Privileged Communication and Confidentiality, J. of Psychiatry and the Law, Vol. 5, No. 3, pp. 415, Fall, 1977. 6

Slovenko, R., Psychotherapy, Confidentiality, and Privileged Communications, American Lecture Series No. 634, 1966. 6

Yalom, Y.D., The Theory and Practice of Group Psychotherapy, 385, Basic Books, Inc. (1970). 3,4

INTERESTS OF AMICUS CURIAE

The Minnesota Medical Association (Association) is a non-profit, voluntary professional association organized in 1853. The organization membership consists of doctors of medicine and doctors of osteopathy who are licensed to practice medicine in the State of Minnesota. The membership includes physicians in numerous specialties, medical educators, student and resident physicians in training, physicians in government health departments and medical directors of corporations. The principal interest of the members of the Association is the health of the public including prevention, evaluation and medical or surgical treatment.

The Minnesota Psychiatric Society (Society) is an organization of physicians licensed in Minnesota who specialize in the practice of psychiatry. The Society is a district branch of the American Psychiatric Association. Approximately 300 of the 325 psychiatrists in Minnesota belong to the Society. Approximately 80 percent of Society members also belong to the Association.

Members of the Association and the Society are committed to the highest principles of medical ethics by the laws of the State and the ethical codes accepted by members of the Association and the Society. In the course of providing medical and psychiatric care, including group psychotherapy, physicians receive intimate details of a patient's life. Professional ethics require that physicians keep in confidence revelations made to

them.[1] Physicians are vigilant to guard against any action which would be contrary to the welfare of their patient. As such, the Court's decision in this case will have significant impact on the ability of a physician to maintain this confidential relationship.

LEGAL ISSUES

I. Whether the scope of the physician-patient and/or registered nurse-patient privilege is to be extended to prevent disclosures of communications concerning Defendant's sexual conduct with minor children during group therapy sessions, a crime for which he has already been charged, where such group therapy sessions are an integral and necessary part of Defendant's diagnosis and treatment and consist of physicians and/or registered nurses and other patients, who participate in said group therapy sessions and are an aid to Defendant's diagnosis and treatment as well as their own, i.e., are such patients to be considered as agents of the physicians and/or registered nurses and/or do such patients come within the meaning of "being reasonably necessary for the accomplishment of the purpose of such a communication" so as to render the relationship confidential?

1/ "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry," American Psychiatric Association (1978); "Current Opinions of the Judicial Council," American Medical Association (1982).

The trial court ruled in the negative.

II. Does Minn. Stat. §626.556(8) (1980) totally suspend the physician-patient privilege in child abuse cases? If not, to what extent, if any, does it suspend such privilege?

The trial court did not rule on this issue.

STATEMENT OF FACTS

Amicus accepts the Statement of Facts as stated in Respondent's brief filed June 24, 1982.

ARGUMENT

I. PATIENTS PARTICIPATING IN GROUP THERAPY SESSIONS ARE REASONABLY NECESSARY FOR THE ACCOMPLISHMENT OF THE PURPOSE OF GROUP THERAPY AND AS SUCH COMMUNICATIONS ARE MADE TO THEM, ARE PRIVILEGED COMMUNICATIONS UNDER MINN. STAT. §595.02(4).

Group therapy is an accepted medical treatment. Irvin D. Yalom, M.D., a leading expert on group therapy wrote in 1970;

> "Group therapy has had a succession of attractive wrappings: it was, during World War II, the economical answer to the shortage of trained therapists; later it became the local treatment arena of the interpersonal theory of psychiatry; and currently it is a medium for alleviating individual and social alienation. Group therapy is not primarily a vehicle for closeness and human contact. <u>It is a method for effecting therapeutic change in individuals.</u> All other goals are metaphenomena and secondary to the primary function of the group."2/ (Emphasis added.)

2/ Yalom, Y.D., <u>The Theory and Practice of Group Psychotherapy</u>, page 385, Basic Books, Inc. (1970)

The American Group Psychotherapy Association Defining Boundaries Task Force proposed the following definition of group psychotherapy.

> "Group psychotherapy is a small, carefully planned treatment system composed of the interactions of a clinically trained therapist and other group members who are clinically assessed for their suitability to the group. The therapist utilizes his or her own, and each group member's emotional, intellectual and non-verbal communications to effect personality change and greater mental health. All group members contract to participate in the group process, which they believe and feel is consistent with their personal goals and emotional difficulties." (Presented for discussion on February 4, 1977 at the annual meeting of the American Group Psychotherapy Association.)

While the physician or other therapist is present at group sessions, the physician's role is not that of a solitary actor, selector, composer, creater or leader of the group. Yalom explains this distinction:

> "There is a fundamental difference in the basic role of the individual therapist and the group therapist. In the individual format the therapist functions as the sole and direct agent of change; in the group therapeutic format he functions far more indirectly. The curative factors in group therapy are primarily mediated not by the therapist but by the other members, who provide the acceptance and support, the hope, the experience of universality, the opportunities for altruistic behavior, and the interpersonal feedback, testing, and learning. It is the therapist's task to help the group develop into a cohesive unit with an atmosphere maximally conducive to the operation of these curative factors."3/

3/ Id. at 85.

As can be seen from Yalom, group therapy cannot function without the presence of patients. But does the essential nature of the patient to the group process come within the test established by Minnesota in State v. Staat 291 Minn. 394, 192 N.W. 2d 192 (1971) for a patient to invoice the privilege granted by Minn. Stat. §595.02(4)? The test stated is a finding that: (1) a confidential physician-patient relationship existed between defendant and the hospital physicians and other persons participating in a defendant's examination and treatment, (2) during which they acquired "information" of the type contemplated by the statute, (3) while attending him, and (4) which was necessary for medical diagnosis and treatment. (Staat, supra at 197).

Clearly, the nature of group therapy placed patients, other than appellant, within the scope of "other persons participating in defendant's...treatment." Likewise the "information" obtained was the kind of private communication which the statute contemplates, namely details of the manifestations of the patient's mental disorder. (This issue of whether certain information normally within the privilege is excluded based on superceding public policy arguments is discussed below.) Likewise disclosure of information to group participants was necessary for proper treatment. Appellant's mental discorder was directly related to the behavior which lead to the charge in this case.

Sound reasons are behind enactment of medical privilege statutes. This historical foundation demonstrates the need for extending the protection to participants in group therapy. In the early 1900's contagious disease was a public health problem which carried significant social stigma. Medical privilege statutes were adopted to encourage patients to seek medical help. Contagious disease stigma is no longer such a significant problem but rather as Slovenko points out:

> "Whereas contagious diseases such as syphilis and leprosy were so stigmatizing that they led to the enactment of medical privilege statutes a half-century ago, today's most stigmatizing label is "psychotic" or "schizophrenic," and there is a comparable concern about confidentiality. Indeed, a psychiatric label today is more stigmatizing than one of gonorrhea."4/

One need only remember the public reaction to Vice-presidential candidate Thomas Eagleton's disclosure in 1972 of his psychiatric care.

The medical privilege statutes come under criticism.4/,5/ But as Saltzburg discusses:

4/ Slovenko, R., Group Psychotherapy: Privileged Communication and Confidentiality, J. of Psychiatry and the Law, Vol. 5, No. 3, page 415, Fall, 1977.

5/ Slovenko, R., Psychotherapy, Confidentiality, and Privileged Communication, American Lecture Series No. 634, 1966; Sadoff, R.L., Informed Consent, Confidentiality and Privilege in Psychiatric Practical Applications, Bull. Am. Acad. Psychiatry and the Law, Vol 2, pp. 101-106, 1974; Redlich, F., Mollica, R.F., Overview: Ethical Issues in Contemporary Psychiatry, Am. J. Psychiatry, Vol. 133, pp. 125-136, 1976; Meissner, W.W., Threats to Confidentiality, Psych. Annals, Vol. 9, pp. 54-71, 1979.

> "Unlike the attorney-client privilege, the doctor-patient privilege has been the subject of a devastating attack. Commentors have argued that few patients would jeopardize their treatment and lie to their doctors out of fear that any information they give a doctor could be used as evidence against them in court. Few patients are even conscious of the privilege when they visit a doctor. Because an opposing party can require a patient or doctor to testify about symptoms, past history, and the patient's visit to a doctor, commentators also have argued that the privilege's narrow scope emasculates its effectiveness.
>
> "Despite the apparent persuasiveness of this attack on the doctor-patient privilege, it ignores a strong justification for the privilege -- The need for privacy. Patients depend on doctors for special counseling and personal attention, and they need a zone of privacy to seek this help. Because medicine involves intimate facts about one's body, health, and mind, the privacy of this treatment and counseling should be protected."6/

Saltzburg's reasoning provides support for physicians and other therapists who, nevertheless, continue to express confusion about the scope and certainty of the physician-patient privilege in individual as well as group therapy.7/

6/ Saltzburg, S.A., Privileged Professionals: Lawyers and Psychiatrists, 66 Va. L. Rev., 597-650, at 617-619, April, 1980.

7/ Meyer, R.G., Smith, S.R., A Crisis in Group Therapy, Am. Psychol., Vol. 32, No. 8, pp. 638-43, August, 1977; Margolin, G., Ethical and Legal Considerations in Marital and Family Therapy, Am. Psychol., Vol. 37, No. 7, pp.788-801, July, 1982; Gumper, L.L., Sprinkle, D.H., Privileged Communication in Therapy: Special Problems for the Family and Couples Therapist, Fam. Process, Vol. 20, No. 1, pp. 11-23,, March, 1981.

Saltzburg's speculation that "few patients" are aware of a specific privilege when consulting a doctor must be questioned in the area of psychiatric patient consultation. Assurances of confidentiality not only are expected by the patient in psychiatric care but in group therapy promises are elicited from each patient in the group to maintain confidences revealed during treatment. Specific promises of confidentiality are also given by the physician during psychiatric consultation and treatment.

Forty-eight statutes from forty-seven states and the District of Columbia create a privilege for either a physician-patient, psychiatrist-patient, psychologist-patient or psychotherapist-patient privilege.8/ The District of Columbia, 9/ Illinois,10/ Rhode Island11/ and Texas12/ specifically exclude group psychotherapy disclosures.

The American Psychiatric Association Model Law on Confidentiality of Health and Social Service Records includes disclosures made in group psychotherapy as confidential. Section 2(f) provides:

8/ Shuman, D.W., Weiner, M.S., The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege, 60 N.C. L. Rev. 893-942 at 907, June, 1982.

9/ D.C. Code Ann. § 2-1704.16 (1981).

10/ Ill. Ann. Stat. Ch. 91-1/2, §810 (Smith-Hurd 1978 & Supp. 1981).

11/ R.I. Gen. Laws, § 5-37. 3-4 (Cumm. Supp. 1981).

12/ Tex. Rev. Civ. Stat. Ann. art. 5561h (Vernon Supp. 1982).

"'In confidence' means, private disclosures made or intended to be made, so far as the discloser is aware, to no other persons except

(i) The intended recipient;
(ii) Those who are present to further the interests of the patient/client in consultation, examination or interview, diagnosis, treatment, or other service provided;
(iii) Those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of diagnosis or treatment, including members of a therapy group of which the patient/client is a participant..."

The confidentiality of psychotherapeutic communications has constitutional underpinnings. Under the federal constitution a patient has a right of privacy which encompasses the right to prevent disclosure of confidences made to a psychotherapist.

In <u>In re Lifschutz</u>, 2 Cal. 3d 415, 467 P. 2d 557, 85 Cal. Rptr. 829 (1970) that Court stated:

> We believe that a patient's interest in keeping such confidential revelations from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. In <u>Griswold v. Connecticut</u>, 381 U.S. 479,484 (1965) the United States Supreme Court declared that "various guarantees (of the Bill of Rights) create zones of privacy," and we believe that the confidentiality of the psychotherapeutic session falls within one such zone. 2 Cal. 3d at 431-2, 467 P.2d at 567, 85 Cal. Rptr. at 839.

This Court, too, has not only squarely recognized the necessity for confidential psychotherapeutic communications, <u>State v. Staat</u>, supra, but has suggested that a cause of action would exist for breach of the duty of confidentiality. <u>Wenniger v. Muesing</u>, 307 Minn. 405, 240 N.W. 2d 333 (1976).

On the federal level, the constitutional right of the patient to the privacy of his communications with his doctor has received repeated attention since 1970. In striking down the abortion laws of Texas and Georgia in Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973), the United States Supreme Court has again recognized the role of the constitutional right of privacy in the doctor-patient relationship. By so doing, the Supreme Court adopted in essence the theory of Justice Douglas' dissent in Poe v. Ullman, 367 U.S. 497 (1961), in which that justice observed:

> "Of course a physician can talk freely and fully with his patient without threat of retaliation by the State. The contrary thought--the one endorsed sub silentio by the courts below--has the cast of regimentation about it, a cast of war with the philosophy and presumptions of this free society, at 513."

And again, in his concurring opinions in Roe v. Wade and Doe v. Bolton, Justice Douglas noted:

> "The right of privacy has no more conspicuous place than in the physician-patient relationship, unless it be in the priest-penitent relationship. 410 U.S. 179 at 219."

As the Second Circuit has more recently noted in Roe v. Ingraham, 480 F. 2d 102, 108 n. 8 (2d Cir. 1973):

> "Indeed there is language in Doe v. Bolton, supra, 410 U.S. at 194, 93 S. Ct. at 739, from which it could be argued that the Court has already taken the step of extending constitutional protection to the privacy of the doctor-patient relationship."

Thus, the constitutional right to the privacy of psychotherapeutic communications, first clearly articulated in In re Lifschutz, has in the years since 1970 been strengthened under state law and federal decisions.

The ethical basis of confidentiality for physicians can be traced back to the principle of Hippocrates that "whatever, in connection with my profession, or not in connection with it, I may see or hear in the lives of men which ought not to be apoken abroad, I will not divulge as reckoning that all should be kept secret." The AMA Principles of Medical Ethics, Principal IV, states, "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law." Annotation to Section 9 especially applicable to psychiatry includes the following statement:

> "1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.
>
> "2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully

apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the student's permission.

"7. Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

"9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients he/she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

"10. With regard for the person's dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering, if the confidentiality of the presentation is understood and accepted by the audience."[13/]

Including all patient participants in group psychotherapy within the physician-patient privilege statute has sound legal support. An additional public policy argument is made by Meyer and Smith.[14/]

13/ Fn 1, supra.

14/ Fn 7, supra, at 641.

> "If a psychotherapist-patient privilege is recognized but does not cover groups, a variant of Gresham's Law may operate. Gresham's Law is a principle of economics which holds that when two kinds of currency of unequal value are in circulation but both are of equal value for the payment of debts, the one of lesser value is paradoxically protected and drives out the currency of greater value. When one form of therapy (individual) is protected by privilege (preferred services) while the other is not (group), the preferred services will tend to "drive out" the non-preferred service. That is, some persons will demand individual therapy because of the existence of the privilege. This, of course, would have the effect of putting an even greater demand on the limited supply of reputable psychotherapeutic services, would tend to deprive some persons (probably in the low and lower-middle income brackets) of the availability of these services, and would also drive patients needing psychotherapy to non-reputable treatment sources."

Some of the Meyer/Smith argument would seem to be undercut by the 1982 report of a study by Shuman and Weiner.[15/] In reporting on perceptions by therapists, patients, lay persons and judges, the authors can find no statistical basis to either support or oppose a psychotherapist-patient privilege. Shuman and Weiner conclude that:

> "Proponents of the psychotherapist-patient privilege contend that it is absolutely necessary for effective therapy; opponents deny this and contend that it seriously impairs the accuracy of judicial proceedings. Our findings suggest that both have overstated their cases...For a small percentage of people the psychotherapist-patient privilege may have a marked bearing on the efficacy of their therapy and in a small percentage of judicial proceedings the psychotherapist-patient privilege may have a marked bearing on the accuracy of the proceedings...This question is not subject to empirical validation but calls instead for a weighing of values."[16/]

15/ Fn 8, supra.

16/ Id at 927-928.

A proper balance of competing interests dictates that Minn. Stat. §595.02(4) should be interpreted to include patients in group psychotherapy in the scope of the physician-patient privilege as other persons participating in treatment. The balance can be achieved by compelling disclosure by the physician as an exception to the statute in those instances where a patient becomes a defendant in a criminal case. To interpret the statute otherwise by compelling other patients to testify but excluding the physician does not serve the public policy detailed above in protecting the privacy of <u>all</u> patients seeking psychotherapy. The statute must be waived in such a manner as to protect the interests of those patients not party to the litigation.

II. THE PHYSICIAN-PATIENT PRIVILEGE IN MINN. STAT. § 595.02(4) SHOULD BE WAIVED WHEN PUBLIC POLICY DICTATES ONLY TO THE EXTENT NECESSARY TO PROVIDE A FOUNDATION FOR INVESTIGATING AND NOT TO COMPEL THE PHYSICIAN TO TESTIFY AGAINST A PATIENT/DEFENDANT'S INTEREST IN AVOIDING SELF-INCRIMINATION.

The Legislature has carved out a public policy that the "State is to protect children whose health or welfare may be jeopardized through physical abuse, neglect or sexual abuse." Minn. Stat. §626.556(1). The law requires an immediate report to the local welfare agency, police department or county sheriff by a "professional or his delegate who is engaged in the practice of the healing arts, social sciences, hospital administration, psychological or psychiatric treatment, child care, education,

or law enforcement who has knowledge of or reasonable cause to believe a child is being neglected or physically or sexually abused." Minn. Stat. §626.556(3).

The Maltreatment of Minors Act provides immunity from liability for reports made in good faith and with due care. Minn. Stat. §626.556(4). The law also allows a voluntary report to be made by "any person" who has "knowledge of or a reasonable cause to believe a child is being neglected or subjected to physical or sexual abuse." Minn. Stat. §626.556(3). Liability protection extends to those making voluntary reports. There is no cross reference to Minn. Stat. §595.02(4) indicating which statute is primary.

The 1975 Maltreatment of Minors Act was adopted subsequent to the establishment of the privilege statute for all professionals except nurses. The 1978 amendments to Minn. Stat. §626.556 were Chapter 755 and followed the amendments to Minn. Stat. §595.02 occurring earlier in the session as Chapter 519 which included nurses within the privilege statute. The inference to be drawn is that the Legislature intended the Maltreatment of Minors Act reporting sections to prevail over the privilege statute.

The American Psychiatric Society Model Law on Confidentiality of Health and Social Services Records supports this by creating an exception to the prohibition against disclosure.

"4. Disclosures Without Authorization:

Consent from the patient/client shall not be required for the disclosure or transmission of confidential information in the following situations, as specifically limited:

> c. Protection from serious injury or disease: The Abused and Neglected Child Reporting Act: Confidential information may be disclosed, (i) in accordance with the provisions of the Abused and Neglected Child Reporting Act." (Emphasis added.)

No parallel exemption is found the the American Medical Association Model State Legislation on Confidentiality of Health Care Information, however.

Other authors have suggested criteria for model privilege statutes which also include limited exceptions for reporting child abuse.[17/]

Since the Maltreatment Reporting Act creates an exception to the privilege statute, this exception should be drawn narrowly. The information requested must be no more than is necessary for law enforcement personnel to act to protect the child from abuse. The information may include the description of the conduct alleged to have occurred along with the name of the alleged perpetrator, the name or names of the suspected victim or victims. There shall be no requirement that the disclosure include information about the patient/alleged perpetrator or

---

17/ Perr, I.N., Doctor-Patient Confidentiality - Suggested Legal Protections, Bull. of the American Academy of Psychiatry and the Law, Vol. 7, No. 3, pp. iv - viii, 1979; Perr, I.N., Privilege, Confidentiality, and Patient Privacy; Status 1980, Jour. of Forensic Sciences, Vol. 29, No. 1, pp. 109-115, January, 1981.

victim and their medical condition to the extent it does not relate to the alleged misconduct.

Other patient participants in group therapy should not be called to testify. A licensed professional, with preference given to a physician, should be called to testify. The physician is more appropriate than a patient for reporting and interpreting statements made in group therapy. Patients in group therapy have an expectation that their participation in group therapy will not become a matter of public knowledge. The court should respect this expectation. The public interest enunciated in the Maltreatment of Minors Act can be served by waiving the privilege for the licensed physician, and not the other patients serving as instruments of treatment in group therapy.

The public interest stated in the Maltreatment of Minors Act, however, must be balanced by the patient/defendant's right against self incrimination. As this court has stated in Staat:

> "Despite persistent academic and judicial criticism of this evidentiary privilege as an impediment to the ascertainment of truth, it is nevertheless our duty to enforce it to the full extent reasonably necessary for the attainment of the longstanding legislative policy for which it was created, namely, to provide a shield for safeguarding and promoting confidential communication between a patient and his attending physician." Id. at 196.

The court in Staat permitted an orderly to testify concerning two vials of drugs found on the patient but excluded testimony by the physician concerning other aspects of the emergency room treatment.

The United States Constitution, Amendment V, protects a person against being "compelled in any criminal case to be a witness against himself." This court recently relied on this principle in finding that statements made to a probation officer were barred from use at trial against defendant, where defendant was not given a warning against self incrimination. State v. Murphy, Fin. & Com. 37:7-9, September 17, 1982, Case No. 82-271.

A similar analysis is appropriate in cases in which a physician is compelled by law to report matters obtained while attending an individual patient. In the case of a court appointed physician conducting an examination, the defendant/patient has a reasonable expectation that the information elicited by the physician will be reported to the court for use at trial. However, in seeking treatment for mental disorder, the defendant/patient has an expectation that his communications will remain confidential unless or until the defendant/patient authorizes disclosure.

The defendant/patient did not do so in this case. The state, therefore, must achieve its objective respecting the privileges of both the defendant/patient and the physician. The role of the physician should be to provide only that information which the state needs to conduct an investigation. Testimonial support for the state's case must come not from the physician as witness but through independent evidence. This allows the defendant/patient to protect from public

disclosure those matters discussed during group psychotherapy that are unrelated to the purpose of the Maltreatment of Minors Act reporting requirements.

CONCLUSION

Patients participating in group therapy are an integral and necessary part of diagnosis and treatment and as such are to be considered as coming within the meaning of "being reasonably necessary for the accomplishment of the purpose of the (medical) communication." The Minnesota Maltreatment of Minors Act waives the privilege statute only to the extent that a professional must disclose the name of the alleged perpetrator, the alleged victim and sufficient other information for law enforcement officials to conduct a proper investigation. Medical reports for the purposes of the Maltreatment of Minors Act shall be considered as evidence for the purposes of prosecution unless substantiated by other evidence.

Respectfully submitted,

KATHLEEN A. MEYERLE

Suite 400, Health Associations Center
2221 University Avenue S.E.
Minneapolis, Minnesota 55414
Telephone: (612)378-1875

Attorney for Amicus Curiae:

Minnesota Medical Association
Minnesota Psychiatric Society