Physician–Patient Privilege

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The Reporting of Child Abuse Argued as an Exception to Physician–Patient Privilege in Criminal Proceedings

In *People v. Rivera*, 33 N.E.3d 465 (N.Y. 2015), the New York Court of Appeals recognized that there is an exception to physician–patient privilege in child-protection hearings. The court considered whether the mandated reporting of child abuse creates an exception to physician–patient privilege in subsequent criminal proceedings.

Facts of the Case

In November 2007, David Rivera was accused of raping and sodomizing his 11-year-old niece. The child reported the abuse to her pediatrician who subsequently reported the case to the Administration for Child Services (ACS). After he heard about the allegation from a family member, Mr. Rivera was taken to the Columbia Presbyterian Hospital (CPH) psychiatric emergency room by ambulance complaining of depression and suicidal ideation. During treatment at CPH, he revealed to his psychiatrist that he had sexually abused the child. The psychiatrist reported the abuse to ACS, as required by the state mandatory child abuse reporting law (N.Y. Soc. Serv. Law § 413 (2014)). There was no evidence that Mr. Rivera was aware of either report to ACS.

Following discharge four weeks later, Mr. Rivera was arrested and charged with predatory sexual assault against a child (N.Y. Penal Law § 130.96 (2014)). The District Attorney subpoenaed any of Mr. Rivera's treatment records from CPH that included admissions Mr. Rivera may have made concerning the predatory sexual assault charge. The district attorney argued that the records could be released as either an exception to privilege or a waiver of the physician–patient privilege. Mr. Rivera countered that he had not waived privilege and referenced N.Y. C.P.L.R. 4504(a) (2012), which states, "unless a patient waives the privilege, a person authorized to practice medicine shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity."

The trial court stated that a defendant's admission to his psychiatrist would be privileged if it were made during the course of diagnosis and treatment. However, the court determined the treating psychiatrist's testimony in this case to be admissible because the abuse had already been disclosed to ACS.

The treating psychiatrist testified that Mr. Rivera admitted to having sexually abused his niece. Mr. Rivera testified that he had not sexually abused the child. During summation, the district attorney referred to the psychiatrist's testimony and, during deliberations, the jury requested a read-back of the testimony. Mr. Rivera was convicted of predatory sexual assault against a child and sentenced to a term of 13 years to life in prison.

Mr. Rivera appealed the decision. The Appellate Division unanimously reversed the conviction and remanded for a new trial (*People v. Rivera*, 4 N.E. 3d 367 (N.Y. 2014)). The appellate court stated the psychiatrist's proper disclosure of the child abuse to ACS did not create an exception to the physician–patient privilege in a criminal proceeding. The court maintained that allowing the psychiatrist's testimony was not harmless error because the jury requested a read-back of only that testimony.

The District Attorney appealed the reversal to New York's highest court, the Court of Appeals of New York.

Ruling and Reasoning

The District Attorney presented three arguments to the court of appeals. The first argument was that physicians are required by law to report suspected cases of child abuse, and Mr. Rivera could not reasonably have expected that physician–patient privilege would apply to his admission to the psychiatrist. The court of appeals responded that exceptions to privilege are narrowly defined. New York law does not contain exceptions to physician–patient privilege for the purpose of criminal proceedings, even when the case involves child abuse. Child-protection hearings are an exception to privilege and differ from criminal proceedings, in that their aim is to ensure the safety of children. The goal of criminal proceedings is to punish the defendant and potentially deprive him of liberty.

Second, the district attorney argued that child-protection objectives would be undermined if the treating psychiatrist could not testify about the reported abuse perpetrated by Mr. Rivera. The court of appeals responded that the child's welfare remained protected without the psychiatrist's testimony as a result of the existence of mandatory reporting statutes.

The district attorney's final argument was that the defendant's psychiatric testimony was harmless error. The court of appeals agreed with the lower court, reasoning that the error was not harmless.

Thus, the Court of Appeals of New York affirmed the decision of the Appellate Division, holding that the trial court violated physician–patient privilege.

Discussion

In 1828, to encourage citizens to seek medical attention, New York became the first state to enact legislation recognizing the physician–patient privilege. At the present time, 44 states have enacted physician–patient privilege statutes. Psychiatrists are covered by psychotherapist–patient privilege in the remaining states. Physician–patient privilege is a legal right of the patient that prevents the physician from testifying about information provided to the physician by the patient that was necessary for diagnosis and treatment. Privilege furthers the doctor–patient relationship and encourages unrestrained communication. It also encourages physicians to fully and accurately record their patients' confidential information (Ciccone JR: Privilege and confidentiality: psychiatric and legal considerations. Psychiatric Med 2: 273–85, 1984).

The importance of privilege was emphasized by the American Psychiatric Association (APA) in a 2010 position statement that identified patients' openness in treatment as reducing danger to society by controlling psychiatric conditions that may lead to violence. (American Psychiatric Association Position Statement on "No 'Dangerous Patient' Exception to Federal Psychotherapist-Patient Testimonial Privilege," Background Information. Available at http://www.psychiatry.org. Accessed December 2, 2015.)

Similarly, the New York State Psychiatric Association emphasized the importance of physician–patient privilege in an *amicus* brief submitted to the New York Court of Appeals in *Rivera*, arguing that privilege should not be sacrificed in the case of mandatory reporting of child abuse to a third party. It stated that evidentiary privilege is important to encourage uninhibited communication between physicians and patients for the purpose of encouraging patients to secure appropriate treatment. The brief also noted that evidentiary privilege shields patients from humiliation, embarrassment, and disgrace by guaranteeing confidentiality (Amicus Curiae Brief for New York State Psychiatric Association, December 9, 2013).

Psychotherapist–patient privilege has been recognized in all 50 states, but it was not until *Jaffee v. Redmond*, 518 U.S. 1 (1996), that this privilege was established in the federal courts. The APA argued in an *amicus* brief that the court should recognize psychotherapist–patient privilege under Federal Rule of Evidence 501. The Fed. R. Evid. 501 was passed by Congress in 1975. Rule 501 did not name specific privileges, but authorized federal courts to create new privileges by interpreting "common law principles . . . in light of reason and experience." This flexible language allowed the contours of privilege to be determined in courts, rather than being rigidly codified. In his majority opinion in *Jaffee*, Justice Stevens wrote that psychotherapist–patient privilege serves important private and public interests. As a private interest, "effective psychotherapy . . . depends on an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of acts, emotions, memories, and fears" (*Jaffee*, p 10). Regarding the public interests Justice Stevens wrote "the mental health of our citizenry, no less than its physical health, is a public good of transcendent importance" because it sustains a "mentally stable society" (*Jaffee*, p 12). *Jaffee* left the outlines of psychotherapist–patient privilege open, to be defined further by subsequent court rulings.

An exception to privilege is not without its limits. In New York State, privilege may be sacrificed for greater interests, such as in cases involving child abuse. Reporting child abuse and testifying at child-protection hearings are essential because they defend children. A limit to this exception to privilege was asserted in *Rivera*, where the court held that mandatory reporting of child abuse does not abrogate privilege in criminal proceedings. Courts have stated that privilege should not be abrogated when there is no imminent danger to avert by the psychiatrist's testimony. In *Rivera*, imminent danger was not present, because the abuse had already occurred by the time of

the criminal trial. Furthermore, it has been argued that the abrogation of privilege in this case would run counter to child-protection objectives because it could discourage individuals from speaking openly to their psychiatrists, thus preventing victims from being warned of potential danger (Amicus Curiae Brief for New York State Psychiatric Association, December 9, 2013). Finally, in *Rivera*, the court found that criminal proceedings require higher evidentiary standards than child-protection proceedings because criminal proceedings may result in the deprivation of liberty.

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Involuntary Outpatient Treatment

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Involuntary Outpatient Treatment Order Requires a Finding That the Individual Will Deteriorate and Become Dangerous to Self or Others in the Near Future

In *In re T.S.S.*, 121 A.3d 1184 (Vt.), the Vermont Supreme Court reversed the Superior Court, Family Division's decision continuing the order of nonhospitalization (ONH) compelling T.S.S. to undergo outpatient mental health treatment.

Facts of the Case

T.S.S. was a 34-year-old man whose psychotic symptoms first appeared in 1999 when he was 18 years old. Among them was a belief that a transmitter had been implanted in his arm. In response to this delusion, he harmed himself and required admission to the Vermont State Hospital. He was released in 2000 with an ONH that compelled him to participate with involuntary outpatient mental health treatment.

In 2002, the state's reapplication for an ONH was denied. In 2003, T.S.S. exhibited several delusions including that his food was poisoned; he appeared emaciated and had fits of rage. After an emergency evaluation, he was hospitalized at Rutland Regional Medical Center (RRMC). He was released in November 2003 on an ONH that was renewed in September 2004. In 2008, RRMC did not file for a renewal of the ONH for him. From late 2008 to 2011, he did not receive mental health treatment. He was arrested in August 2011 on the misdemeanor charge of unlawful mischief causing damage greater than $250 for breaking windows. In March 2012, he was found incompetent to stand trial. In August 2012, he was placed on an ONH and his charge was dismissed. In June 2013, he did not contest the commissioner's filing for renewal of the ONH.

In February 2014, the commissioner filed for another renewal of T.S.S.'s ONH. T.S.S. objected. At the hearing, his psychiatrist told the court that T.S.S.:

> . . . has demonstrated a clear pattern that for a short period of time, despite denying that he has a mental illness, he, on orders of the non-hospitalization, will take medications and improve significantly. But when he is off the order of non-hospitalization he quickly goes off medication and deteriorates [*T.S.S.*, p 1185].

The psychiatrist also testified that, "I cannot predict the timing because there was a four-year . . . [or] three-year period that he was off [court] orders" (*T.S.S.*, p 1186). The psychiatrist went on to report that T.S.S. did not like being on an ONH or the side effects of some of his medications.

In May 2014, the court granted the ONH. It found that without his current treatment, T.S.S. would "eventually . . . become a person in need of treatment. It is the nature of his particular mental illness that such predictions are very difficult. However, he will reach that point" (*T.S.S.*, p 1187). T.S.S. appealed, arguing that the court misinterpreted the Vermont statute Vt. Stat. Ann. tit. § 7101(16) (2013) regarding ONH by not requiring a showing that the person is likely to become a danger to self or others in the near future without treatment. He further argued that the court's ruling was not consistent with the evidence.

Ruling and Reasoning

The Vermont Supreme Court unanimously vacated the lower court's ONH. The court found that the Department of Mental Health may not be granted an ONH for a psychiatric patient unless it proves that the patient, without treatment, is likely to become dangerous in the near future.