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Daniel W. Shuman

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The Road to Bedlam:* Evidentiary Guideposts in Civil Commitment Proceedings

*Daniel W. Shuman***

I. Introduction

In contrast with the dearth of judicial intervention into civil commitment of the mentally ill prior to 1968,[1] the past decade has witnessed an explosion of litigation concerning the procedural and substantive rights of the mentally ill.[2] Whatever may be the precise current parameters of these rights,[3] civil commitment entails a deprivation of liberty which is cognizable under the due process clause of the fourteenth amendment of the United States Constitution.[4] Those courts which have addressed the evidentiary requirements compelled by the due process clause in the context of a civil commitment hearing[5] have required

* Bedlam was the popular name for St. Mary of Bethlehem, a place of confinement devoted to the insane. R. Hunter and I. Macalpine, *Three Hundred Years of Psychiatry, 1535-1860* (1963).

** Assistant Professor of Law, Southern Methodist University. J.D., University of Arizona, 1972.

1 *See Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974) [hereinafter cited as *Developments in the Law*]. *See also Legal Issues in State Mental Health Care: Proposals for Change*, 2 MEN. DIS. L. REP. 57, 58 (1977). This latter publication contains the legislative guide of the Mental Health Law Project, a private organization sponsored by the American Orthopsychiatric Association, the Center for Law and Social Policy, and the American Civil Liberties Union Foundation. The legislative guide will be used throughout this article in examining alternative responses to particular issues.

2 Compare the remarks of Mr. Justice Jackson in Jackson v. Indiana, 406 U.S. 715, 737 (1972): "Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." Two lawsuits which have exemplified this litigation are: Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), 344 F. Supp. 387 (M.D. Ala. 1972), 503 F.2d 1305 (5th Cir. 1974); and Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1973), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

3 A prerequisite to the analysis of the state's power to civilly commit a person because of mental illness is the answering of certain core questions bearing on the very existence of the power to commit persons under any circumstances for mental illness. In O'Connor v. Donaldson, 422 U.S. 563 (1975), the Supreme Court raised, but did not answer, certain fundamental questions concerning the existence or proper use of this power. "We need not now decide whether, when, or by what procedures, a mentally ill person may be confined by the State . . . ." *Id.* at 573.

Subsequently, in Addington v. Texas, 99 S. Ct. 1804, 1809 (1979), the Court stated, without citation of authority or supporting analysis:

> The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.

Notwithstanding this recognition of the *parens patriae* and police power justifications for civil commitment, the question "when, or by what circumstances, a mentally ill person may be confined by the State" is still largely unanswered.

4 99 S. Ct. at 1809; 422 U.S. at 580 (Burger, C.J., concurring); Specht v. Patterson, 386 U.S. 605, 608 (1967); *Developments in the Law*, *supra* note 1, at 1193-1201.

5 Implicit in the decision of the United States Supreme Court in Addington v. Texas, 99 S. Ct. 1804 (1979), that civil commitment proceedings require the use of the clear and convincing evidence standard of persuasion, is a recognition that an adversary hearing where evidence which will be adduced and subsequently tested by the clear and convincing evidence standard is also constitutionally required. This conclusion is not weakened by the Court's subsequent decisions in Parham v. J.R., 99 S. Ct. 2493 (1979), and Secretary of Pub. Welfare of Pa. v. Institutionalized Juveniles, 99 S. Ct. 2523 (1979), which held that adversary proceedings are not constitutionally required for commitment of juveniles to state mental institutions by parents. Conscious of its decision in *Addington* only two months earlier, the Court carefully limited its holding in *Parham*, 99 S. Ct. at 2496, and *Secretary of Public Welfare*, 99 S. Ct. at 2524, to minor children

the use of evidentiary rules applicable in other judicial proceedings.[6] Moreover, numerous state legislatures have amended their state statutes to require the use of traditional evidentiary rules in civil commitment proceedings.[7]

These judicial or legislative determinations to utilize the rules of evidence in civil commitment proceedings are not, however, the final answer to the questions of evidentiary requirements for commitment proceedings. Rather they serve to usher in a host of other issues—a second generation of issues pertaining to civil commitment of the mentally ill. To clarify the issues raised by the interface of rules of evidence and civil commitment it is helpful to engage in certain preliminary observations of each.

An event is in dispute in a pending lawsuit. The fact-finder can never acquire "unassailably accurate knowledge" of that past event; rather, the best that might be expected is to acquire knowledge of what probably happened.[8] To maximize this probability two cardinal principles have been accepted as the basis for any rational system of evidence: "(1) that nothing is to be received [into evidence] which is not logically probative of some matter requiring to be proved; and (2) that everything which is thus probative should come in, unless a clear ground of policy or law excludes it."[9] A major determinant of those rules of evidence which have resulted in the exclusion of probative evidence is the policy which seeks to protect juries from evidence thought to be beyond their capacity to evaluate properly.[10] The assumptions which underlie exclusion of evidence based upon jury incapacity have been subjected to increased

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whose parents sought institutional mental health care for the children. Moreover, the Court's reasoning in these cases is bottomed upon the "traditional presumption that the parents act in the best interests of their child[ren]." 99 S. Ct. at 2505. Because commitment of adults does not turn upon parental decision-making, "adults facing commitment to mental institutions are entitled to full and fair adversarial hearings in which the necessity for their commitment is established to the satisfaction of a neutral tribunal." *Id.* at 2516 (Brennan, J., concurring and dissenting).

The civil commitment hearing referred to here and discussed throughout this article is the "full hearing" as contrasted with a preliminary hearing used to scrutinize a brief period of confinement prior to the opportunity to conduct the "full hearing." *See Developments in the Law, supra* note 1, at 1275-82. For a discussion of some of the issues raised by the preliminary hearing, see Note, *"We're Only Trying to Help": The Burden and Standard of Proof in Short Term Civil Commitment,* 31 STAN. L. REV. 425 (1979).

6 Suzuki v. Quisenberry, 411 F. Supp. 1113, 1127 (D. Hawaii 1976) ("rules of evidence applicable in criminal cases"); Doremus v. Farrell, 407 F. Supp. 509, 517 (D. Neb. 1975) ("The Court cannot discern a rational basis for admitting evidence in a final civil commitment hearing which would be inadmissible in criminal trials."); Lynch v. Baxley, 386 F. Supp. 378, 394 (M.D. Ala. 1974) ("[R]ules of Evidence applicable to other judicial proceedings"); Lessard v. Schmidt, 349 F. Supp. at 1103 ("rules of evidence generally applicable to other proceedings in which individual's liberty is in jeopardy"); Holm v. State, 404 P.2d 740, 745 (Wyo. 1975) ("the court shall consider . . . itself bound by the rules of evidence . . ."). *See also In re* Gault, 387 U.S. 1, 56-57 (1967).

7 *See, e.g.,* ALA. CODE § 22-52-9 (5) (Cum. Supp. 1977); ARIZ. REV. STAT. ANN. § 36-539(D) (1974); IDAHO CODE § 66-329(h) (Cum. Supp. 1978); ME. REV. STAT. ANN. tit. 34, § 2334(4)(C) (1978); MONT. REV. CODES ANN. § 38-1304(4)(f) (Cum. Supp. 1977); NEB. REV. STAT. § 83-1059 (1976); N.D. CENT. CODE § 25-03.1-19 (1978); S.C. CODE § 44-17-570 (1976); UTAH CODE ANN. § 64-7-36(5) (Supp. 1977); WASH. REV. CODE ANN. § 71.05.310 (1975); W. VA. CODE § 27-5-4(c) (1976).

Other legislatures have provided, without specific reference to evidentiary rules, that the procedures for commitment of the mentally ill will be the same as the procedures utilized in other judicial proceedings. COL. REV. STAT. § 27-10-111(1) (1973); DEL. CODE ANN. § 16-5006(4) (Cum. Supp. 1977); IND. CODE ANN. § 16-14-9.1-13 (Burns Cum. Supp. 1979); OHIO REV. CODE ANN. § 5122.15(A)(15) (Page Supp. 1977). From this it may be reasonably inferred that the evidentiary rules utilized in other judicial proceedings within these jurisdictions, as an aspect of their adjudicatory procedures, are applicable to civil commitment proceedings.

8 *In re* Winship, 397 U.S. 358, 370 (1970) (Harlan, J., concurring.)

9 J. THAYER, A PRELIMINARY TREATISE ON EVIDENCE AT THE COMMON LAW 530 (1898).

10 J. THAYER, *supra* note 9, at 508-09. Another policy which results in the exclusion of probative evidence is that of privilege which seeks to protect certain relationships by rendering the contents of relational communications immune from judicial disclosure. *See* text accompanying notes 56-154 *infra.*

scrutiny.[11] As a result, a shift towards an assumption of greater jury sophistication with a concomitant bias in favor of admissibility has occurred.[12] This predilection towards receipt of evidence is also supported by the availability of discovery and other pretrial procedures designed to avoid surprise at trial. Consequently, counsel are able to take those steps prior to trial necessary to respond to evidence in a manner which will permit the fact-finder to evaluate it properly.[13]

Against this background, procedures for civil commitment of the mentally ill, which often hold the potential of confinement for life,[14] have characteristically lacked rigorous judicial scrutiny or zealous patient advocacy.[15] Without questioning the reliability of documents received into evidence, the foundation for conclusory expert testimony, or the expertise of the purported experts, counsel and court would, more often than not, function as the legal rubber stamp of approval for unchallenged medical judgments.[16] Recent judicial and legislative decisions constitute a mandate for change of this situation.[17]

To what extent are the reforms which have taken place in the law of evidence outside civil commitment appropriate for civil commitment, so long a stepchild of the legal system? Are more restrictive evidentiary requirements necessary for commitment or will the more liberal approach to the receipt of evidence suffice? These critical questions require an analysis of predictable evidentiary issues in civil commitment proceedings.[18]

II. Which Road to Travel?

A. *The Justification for Traditional Evidence Rules*

The deprivation of liberty which results from an order of commitment gives rise to the constitutional arguments in favor of applying general evidentiary rules to civil commitment proceedings. The due process and equal protection clauses of the fourteenth amendment are clearly implicated in such arguments. The due process argument suggests that a judicially sanctioned

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11 Weinstein, *Preface* to E. MORGAN, BASIC PROBLEMS OF STATE AND FEDERAL EVIDENCE at xi (5th ed. J. Weinstein 1976).

12 *Preface* to I.J. WEINSTEIN & M. BURGER, WEINSTEIN'S EVIDENCE at iii (1978) [hereinafter cited as WEINSTEIN].

13 *Id.*

14 *Developments in the Law, supra* note 1, at 1193.

15 Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill,* 44 TEX. L. REV. 424, 428-30 (1966); Wexler & Scoville, *Special Project—The Administration of Psychiatric Justice: Theory and Practice in Arizona,* 13 ARIZ. L. REV. 1, 51-60 (1971).

More recently the legal representation of virtually all persons committed in Milwaukee County who were represented by a closed panel of attorneys was found to constitute ineffective assistance of counsel. State *ex rel.* Memmel v. Mundy, No. 441-417 (Wis. County Cir. Ct. Aug. 18, 1976), *appeal dismissed,* 75 Wis. 2d 276, 249 N.W.2d 573 (1977).

16 Wexler & Scoville, *supra* note 15, at 51-60.

17 *See* notes 4 and 6 *supra.*

18 The choice of evidentiary rules applicable in state judicial proceedings is in large measure left to the discretion of the state, a point recently reaffirmed in the Federal Rules of Evidence. Thus, although the judicial system of each state should focus upon the same issues, the resolution by each state of these issues will differ. Rather than attempting to analyze each state system, this article will primarily utilize the recently codified Federal Rules of Evidence as a vehicle for discussing approaches to particular problems.

deprivation of liberty requires filtration of the evidence through the traditional, judicially applied rules of evidence. None of the courts which have concluded that due process considerations require application of traditional judicial evidence rules have articulated why those rules need apply rather than some other less formalistic system of evidentiary rules.[19]

The assumption which must underlie a rejection of a less formalistic evidentiary system[20] is that each judicial evidentiary rule is required by the due process clause in all judicial proceedings involving the potential for loss of life, liberty, or property. Although many rules, such as the hearsay rule, are in whole or part supported by due process considerations,[21] other evidentiary rules are supported by considerations other than due process. The rules excluding offers to compromise[22] or evidence of subsequent repairs,[23] and limiting cross-examination to the subject matter of direct examination illustrate these competing considerations.[24] Thus, where wholesale incorporation of judicial evidentiary rules falters under due process analysis, the equal protection analysis provides additional constitutional support for application of traditional evidentiary rules in commitment proceedings.

Under the equal protection analysis, the mere fact that an individual rule is not supported by due process considerations is not fatal. If the rule has been regularly applied in other judicial proceedings, equal protection scrutiny would focus upon the existence of a rational basis for disparate application of the rule in commitment proceedings.[25] Under such an analysis, one might question the use of less stringent standards for admission of expert medical testimony in commitment than in criminal or personal injury actions. Because the rational basis test may not result in the most demanding scrutiny, it is conceivable that certain bases for distinction could survive equal protection scrutiny.

In addition to these constitutional supports, a less legalistic, and perhaps more appealing argument exists for application of traditional judicial evidentiary rules. "[T]o the extent that the rules of evidence are not merely technical or historical, but like the hearsay rule have a sound basis in human experience, they should not be rejected in any judicial inquiry."[26] The appliction of judicial evidentiary rules is most clearly supported in *Lessard v. Schmidt*[27] and *Suzuki v. Quisenberry*.[28] Thus, if the constitutional arguments in favor of traditional judicial evidentiary rules are found lacking, extra-constitutional considerations justify application of the rules of evidence in civil commitment proceedings.

19 *See* Lynch v. Baxley, 386 F. Supp. at 394; Lessard v. Schmidt, 349 F. Supp. at 1102-03.

20 *See, e.g.*, Mathews v. Eldridge, 424 U.S. 319, 344-45 (1976).

21 *Hearsay—Confrontation and Due Process*, 56 F.R.D. 183, 291 (1973) (Advisory Committee overview of the approach to hearsay taken by the Federal Rules of Evidence).

22 FED. R. EVID. 408, Adv. Comm. Notes, 56 F.R.D. 183, 227 (1973) (encouragement of compromise in the settlement of disputes).

23 FED. R. EVID. 407, Adv. Comm. Notes, 56 F.R.D. 183, 225-26 (1973) (encouragement of safety measures or at minimum avoidance of discouraging safety measures).

24 FED. R. EVID. 611(b), Adv. Comm. Notes, 56 F.R.D. 183, 274 (1973) (orderly management of the trial).

25 Jackson v. Indiana, 406 U.S. 715 (1972).

26 Note, *Juvenile Delinquents: The Police State Courts, and Individualized Justice*, 79 HARV. L. REV. 775, 795 (1966), *quoted with approval in In re* Gault, 387 U.S. at 11 n.7.

27 349 F. Supp. at 1102-03.

28 411 F. Supp. at 1130.

B. *Civil or Criminal Rules*

The opinion of the federal district court in *Suzuki v. Quisenberry*[29] which requires that civil commitment proceedings be conducted according to the "rules of evidence applicable in *criminal* cases"[30] and that of the federal district court in *Doremus v. Farrell*[31] which requires exclusion of evidence in commitment proceedings "which would be inadmissible in *criminal* trials"[32] raise a preliminary issue—which rules of evidence should apply, those applicable in criminal or civil cases? To answer this question it is useful to pose another preliminary question—are there different rules of evidence for civil and criminal cases? In those jurisdictions without codified rules of evidence, such as Hawaii, the judicial response has been that the "general rules as to the admissibility of evidence are the same in criminal as in civil proceedings."[33]

Where systems of evidentiary rules have been codified, as for example in the Federal Rules of Evidence,[34] the rules have been expressly made applicable in civil and criminal cases.[35] Such dual application is consistent with those of the draftsmen of the American Law Institute's Model Code of Evidence[36] and of the Uniform Rules of Evidence.[37] What then accounts for the perception exemplified in *Suzuki*[38] and *Doremus*[39] that there are different rules of evidence in civil or criminal cases?

One author suggests that this perceived difference can be explained by the fact that certain rules arise primarily in criminal trials.[40] More probably, however, certain constitutionally compelled procedural requirements give rise to the most vivid differences in the procedures for trials of civil and criminal cases. Perceptions that there are different rules of evidence in civil and criminal cases result from such constitutional procedural requirements as the standard of persuasion,[41] the privilege against self-incrimination,[42] and the confrontation clause.[43] As will be explained, each of these constitutionally engendered concerns can and should be considered separately from general rules governing the admission of evidence.[44]

The "standard of proof represents an attempt to instruct the fact finder

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29 *Id.* at 1127.
30 *Id.* (emphasis added).
31 407 F. Supp. 509 (D. Neb. 1975).
32 *Id.* at 517 (emphasis added).
33 State v. Danforth, 73 N.H. 215, 220, 60 A. 839, 842 (1905). *Accord,* State v. Cooper, 2 N.J. 540, 555, 67 A.2d 298, 305 (1949); State v. Heavner, 146 S.C. 138, 143 S.E. 674 (1928). *See also* United States v. Gooding, 25 U.S. 460, 469 (1827).
34 28 U.S.C. app. (1976).
35 FED. R. EVID. 1101(b). *But see* FED. R. EVID. 201(g), 301, 302, 404, 501, 601, and 803(8).
36 MODEL CODE OF EVIDENCE rules 1(1) and 2 (1942).
37 UNIFORM RULES OF EVIDENCE 101 and 1101(a). *But see* Harvey, *The Uniform Rules of Evidence as Affected by the Federal Constitution, and as Accepted by One State,* 29 MONT. L. REV. 137 (1968), which argues in favor of separate rules of evidence in civil and criminal cases.
38 411 F. Supp. at 1127.
39 407 F. Supp. at 517.
40 I.F. WHARTON, CRIMINAL EVIDENCE § 1, at 1 (13th ed. 1972). As an illustration the author notes the rules which apply to the defendant's prior conviction and evidence of the defendant's character or reputation. *Id.*
41 *In re* Winship, 397 U.S. 358 (1970).
42 U.S. CONST. amend. V.
43 U.S. CONST. amend. VI.
44 Curiously, although the opinion in *Suzuki* concludes that criminal evidence rules apply, the opinion discusses the standard of persuasion, privilege against self-incrimination, and confrontation as separate requirements. 411 F. Supp. at 1127, 1130-32.

concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication."[45] The standard functions independently of the rules that govern receipt of evidence. In applying a particular standard of persuasion, the fact-finder's decision to return a verdict for one party or another turns upon that which has been received into evidence and only indirectly on that which has been rejected and is therefore not now available to support or upset a verdict.[46] Recently the Supreme Court decided that the appropriate standard of persuasion for use in civil commitment proceedings is the "clear and convincing" standard.[47] The framing of this standard does not affect the threshold requirements for the receipt of evidence at trial. Thus, the standard of persuasion and the rules governing admission of evidence may be considered separately.

Whether one may invoke the protections of the privilege against self-incrimination contained in the fifth amendment does not turn upon the judicial context in which the privilege is asserted but rather upon the consequences which may flow from compelled testimony.[48] Whether the amendment's protection should be applicable to commitment proceedings is an issue separate from other aspects of the standards for receipt of evidence.[49] Accordingly, the self-incrimination clause is not germane to this analysis.

Another constitutional protection distinguishing trials in civil and criminal

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45 397 U.S. at 370 (Harlan, J., concurring).

46 It might be argued that where society demands a higher degree of correctness a more rigorous standard of threshold admissibility should be employed. For example, where the eyewitness to an event is a chronic alcoholic who has twice been convicted of perjury we might wish to permit his testimony in a civil case but not a criminal case because his testimony fails to satisfy a minimal standard of threshold reliability. Exclusion of this testimony, however, leaves us with a less complete picture of the event at issue and therefore with a lesser probability that its judicial reconstruction will be correct. Additionally, the standard of persuasion recognizes that error in the fact-finding process will occur and incorporates the societal demand that its negative consequences fall in particular patterns—equally on the parties in civil litigation and on the government in criminal cases governed by the reasonable doubt standard. A higher threshold of admissibility would not serve this goal.

47 Addington v. Texas, 99 S. Ct. at 1809. The *Addington* decision is troubling for several reasons. First, the Court fails to recognize any difference in the standard which should result where the commitment is based upon the police power versus *parens patriae* model. The standard of persuasion reflects a societal judgment concerning the consequences of an erroneous decision. This judgment should be affected by the specific type of danger an erroneous release may pose, the amenability of a particular disorder to treatment, and the aversive nature of the treatment for the particular disorder.

Second, the Court fails to address the potential length of deprivation of liberty in relationship to the standard of persuasion. *Addington* involved an indefinite commitment. Should a different standard of persuasion be applied to commitments of finite duration? The Court specifically recognizes that the standard of persuasion reflects societal concerns with liberty, yet it *fails* to condition the standard on the extent of the deprivation—short-term emergency, temporary, or indefinite.

The Court recognizes that the formulation of the standard of persuasion must consider not only the patient's interest in liberty but society's interest in reducing dangerousness through confinement and treatment. What is particularly disturbing about this aspect of the opinion is that its author, Chief Justice Burger, fails to follow through with the analytical precision he demonstrated in his concurring opinion in O'Connor v. Donaldson, 422 U.S. 563, 580 (1976).

In *O'Connor,* Burger reviewed the available literature which suggested that treatment for the involuntarily committed patient has not been effective. 422 U.S. at 584. Curiously in *Addington,* Burger has neglected to refer to the available literature which suggests that commitment is not likely to be effective in reducing societal dangerousness because of prediction problems and that involuntary treatment has not been shown effective. *See* notes 132-35 *infra.* If these state interests are not likely to be served in civil commitment proceedings, a reexamination of the balance struck by the Court between the individual and state interest should occur.

48 *In re* Gault, 387 U.S. at 49; Murphy v. Waterfront Comm'n, 378 U.S. 52 (1964); Malloy v. Hogan, 378 U.S. 1 (1964).

49 The application of the privilege against self-incrimination to civil commitment proceedings is discussed in the text accompanying notes 173-227 *infra.*

cases is the confrontation clause of the sixth amendment.[50] Recent opinions considering the protections of the confrontation clause in light of long-standing exceptions to the hearsay rule have concluded that, although both are intended to serve much the same purpose, the confrontation clause is not a constitutionalized hearsay rule.[51] Evidence which falls within an exception to the hearsay rule may not survive scrutiny under the confrontation clause.[52] Conversely, nonexclusion under the confrontation clause does not automatically result in immunity from exclusion under the hearsay rule.[53]

In light of this less than complete overlap, the drafters of the Federal Rules of Evidence wisely chose to separate the confrontation clause from the hearsay rule.[54] Survival of scrutiny under the hearsay rule simply exempts the evidence from exclusion under the hearsay rule. Scrutiny under the confrontation clause may still take place. No cogent reason exists to vary that approach with respect to civil commitment.[55] Whether the confrontation clause applies to commitment may therefore be discussed separately from the hearsay rule.

Thus the constitutionally compelled procedural requirements which often distinguish civil and criminal trials do not require different sets of rules governing the admissibility of evidence. Rather, where these constitutional requirements are applicable, they necessitate another level of scrutiny of evidence prior to its admission or they do not at all bear upon admission of evidence. In either case there is but one road even though additional tolls may occasionally be assessed for different travelers.

III. The Signs Along the Way

A. *Psychiatric Testimony*

1. The Psychotherapist-Patient Privilege

Civil commitment proceedings, whether utilizing some form of need of treatment[56] or danger standard,[57] require that the fact finder address the patient's present mental health and future mental health without commitment. Courts[58] and legislatures[59] have articulated a need for psychiatric[60] input to ad-

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50 U.S. CONST. amend. VI provides in part: "In all criminal prosecutions, the accused shall enjoy the right . . . to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor . . . ."

51 Dutton v. Evans, 400 U.S. 74 (1970); California v. Green, 399 U.S. 149 (1970). Those who find this conclusion and its consequences less than satisfying may find solace in Graham, *The Confrontation Clause and the Hearsay Rule: Sir Walter Raleigh Loses Another One,* 8 CRIM. L. BULL. 94 (1972).

52 Barber v. Page, 390 U.S. 719 (1968); Pointer v. Texas, 380 U.S. 400 (1965).

53 399 U.S. at 156.

54 *Hearsay—Confrontation and Due Process,* 56 F.R.D. 183, 292 (1973). *See also* United States v. Oates, 560 F.2d 45, 76 (2d Cir. 1977).

55 For a discussion of the application and requirements of the confrontation clause in the context of civil commitment, see text accompanying notes 284-308 *infra.*

56 *Developments in the Law, supra* note 1, at 1201-07.

57 *Id.*

58 *E.g., In re* Gannon, 123 N.J. Super. 104, 105, 301 A.2d 493, 494 (1973) ("[I]n a commitment proceeding . . . the court is in effect bound by the expertise of the psychiatrist . . . .").

59 Most states require a pre-hearing medical examination to be performed by a physician. S. BRAKEL & R. ROCK, THE MENTALLY DISABLED AND THE LAW 50 (1971).

60 Throughout this article the problems of physician testimony in commitment proceedings will be addressed as a question of psychiatric testimony.

dress these issues in commitment proceedings. Although the desire for psychiatric testimony in these proceedings is understandable, the obligatory aspect of such testimony in many jurisdictions[61] and the unprecedented judicial deference to such testimony are remarkable.[62] This combination of circumstances heightens the importance of scrutinizing the conditions for receipt of psychiatric evidence.

Psychiatrists will ordinarily require some degree of familiarity with the patient if they are to assist the court in a civil commitment proceeding.[63] There are a variety of possible ways in which the psychiatrist can acquire sufficient firsthand knowledge[64] of the patient to aid the court in a resolution of the issues raised by the proceedings. The following hypotheticals represent some predictable patterns which may arise in commitment proceedings and are set forth as vehicles for further analysis of the problems which arise from psychiatrist-patient relationships and judicial testimony. (1) A patient may have voluntarily[65] chosen to seek private outpatient psychiatric care with a particular psychiatrist. Subsequently, the patient's condition may have deteriorated to the point that someone[66] instituted commitment proceedings and this psychiatrist is subpoenaed to testify. (2) Following the institution of proceedings for commitment, a psychiatrist may have been appointed by the court to examine the patient to render an opinion concerning the patient's committability.[67] (3) A psychiatrist treating an involuntary inpatient[68] may be called upon to testify at a judicial review or recommitment proceeding. To varying degrees, each of these hypotheticals poses the question whether the manner in which the psychiatrist acquired information concerning the patient should be cloaked with a privilege which would give the patient the right to preclude the introduction of any or all testimony by that psychiatrist.

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61 In Texas, for example, the state constitution requires that commitments be supported by "competent medical or psychiatric testimony." TEX. CONST. art. I, § 15a.

62 Wexler & Scoville, *supra* note 15, at 60. This study of commitment proceedings in Arizona found that doctors' recommendations were followed in 97.9% of the commitment proceedings in Phoenix, Arizona, and in 96.1% of the commitment proceedings in Tucson, Arizona.

63 This assumes that the psychiatrist applies his knowledge and experience to the patient's situation and offers his opinion on the patient's condition. Conceivably, the psychiatrist might simply expound certain principles of psychiatric wisdom leaving the judge or jury to apply these to the facts of the case. FED. R. EVID. 703, ADV. COMM. NOTES, 56 F.R.D. 183, 282 (1973).

64 Rheingold, *The Bases of Medical Testimony,* 15 VAND. L. REV. 473 (1962). Three categories of information may provide the bases for expert opinion in a judicial proceeding—firsthand observation, trial testimony, and information from third parties outside of the trial. *Id.* at 480.

65 Even voluntary treatment is potentially coercive. It is questionable if a patient can be considered "voluntary" when his purpose in seeking psychiatric help is to avoid extreme psychological pain, incarceration, or the loss of a professional license. S. HALLECK, PSYCHIATRY AND THE DILEMMAS OF CRIME 314 (1967).

Moreover, in the context of voluntary psychiatric hospitalization, the "voluntary" hospitalization of a child by a parent or of a ward by a guardian cloaks such proceedings with a label that belies reality. *See* Gilboy & Schmidt, *Voluntary Hospitalization of the Mentally Ill,* 66 NW. U.L. REV. 429 (1971). *But see* Parham v. J.R., 99 S. Ct. 2493 (1979), and Secretary of Pub. Welfare of Pa. v. Institutionalized Juveniles, 99 S. Ct. 2523 (1979), where the Court concluded that an adversary proceeding is not constitutionally required before a minor child may be administered institutional mental health care at the request of a parent or guardian.

66 *See* Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 432, 551 P.2d 334, 341, 131 Cal. Rptr. 13, 21 (1976), discussed at note 121 *infra,* which raises questions of privilege.

67 Although local practice may vary, this factual scenario assumes that even if the patient is ultimately committed, he will have no further contact with this examining psychiatrist.

68 For a discussion of the right not to receive treatment, see Schwartz, *In The Name of Treatment: Autonomy, Civil Commitment and the Right to Refuse Treatment,* 50 NOTRE DAME LAW. 808 (1975); *Developments in the Law, supra* note 1, at 1344.

The primary function of a trial is to shed light on those matters at issue.[69] Accordingly, a principal tenet of a rational system of evidence is the desire to receive evidence probative of those matters at issue.[70] Other social policies may, however, conflict with the desire to receive probative evidence. For example, in certain circumstances, nondisclosure of information which is probative of issues in the case is thought to be essential to the protection of a relationship to which society ascribes great importance. The result of a balance struck in favor of nondisclosure of information arising out of this relationship is a privilege which provides a right to limit judicial disclosure of the communications.[71] This balancing has resulted in rules of privilege which have been applied to a panoply of different relationships, including attorney-client,[72] husband-wife,[73] priest-penitent,[74] and physician-patient.[75]

Historically the notion of a physician-patient privilege has been accorded a less than cordial reception. The common law recognized no privilege which could prevent the physician from being compelled to reveal probative information learned from a professional relationship.[76] Accordingly, only legislative action would suffice to protect such communications from compelled judicial disclosure.[77] Although this common law rule has been abrogated in a majority of states by physician-patient privilege statutes,[78] the privileges created by these statutes have been so riddled with exceptions that the protection they provide is slight.[79] These exceptions have responded to the multitude of commentators who have, with varying degrees of ferocity, attacked the desirability of a

69 FED. R. EVID. 102. As the language of the rule implies, however, the search for truth is tempered by a multitude of other factors. *See* Weinstein, *Some Difficulties in Devising Rules for Determining Truth in Judicial Trials*, 66 COL. L. REV. 223, 241 (1966).

70 *E.g.*, United States v. Nixon, 418 U.S. 683, 709 (1974):

> The need to develop all relevant facts in the adversary system is both fundamental and comprehensive. The ends of criminal justice would be defeated if judgments were to be founded on a partial or speculative presentation of the facts. The very integrity of the judicial system and public confidence in the system depend on full disclosure of all the facts, within the framework of the rules of evidence.

71 McCormick, *The Scope of Privilege in the Law of Evidence*, 16 TEX. L. REV. 447-48 (1938):

> They do not in any wise aid the ascertainment of truth, but rather they shut out the light. Their sole warrant is the protection of interests and relationships which, rightly or wrongly, are regarded as of sufficient social importance to justify some incidental sacrifice of sources of facts needed in the administration of justice.

Not all persons who have analyzed evidentiary privileges agree that they are exclusionary rules triggered by a balancing analysis. Professor Louisell has contended instead that privileges are primarily "a right to be let alone . . . in certain narrowly prescribed relationships, from the state's coercive or supervisory powers," and only incidentally result in the exclusion of evidence. Louisell, *Confidentiality, Conformity and Confusion: Privileges in Federal Court Today*, 31 TUL. L. REV. 100, 110-11 (1956).

72 8 J. WIGMORE, A TREATISE ON THE ANGLO AMERICAN SYSTEM OF EVIDENCE IN TRIALS AT COMMON LAW § 2290 (McNaughton rev. ed. 1961).

73 *Id.* § 2332.

74 *Id.* § 2394.

75 *Id.* § 2380.

76 *See* Duchess of Kingston's Case, 20 How. St. Trials, 355, 573 (1776). *But see* Allred v. State, 554 P.2d 411 (Alas. 1976).

77 *See* text accompanying notes 155-72 *infra*, concerning potential constitutional analogs to the physician-patient privilege. Note that the formal ethical limitations imposed upon the psychiatrist as a member of the medical profession create no barrier to compelled judicial disclosure. The ethical limitation on revelation of patient confidences specifically excepts disclosure required by law. Section 9 of the Principles of Medical Ethics, American Medical Association, 130 AM. J. PSYCH. 1058, 1059 (1973).

78 8 J. WIGMORE, *supra* note 72, § 2380, at 819 n.5.

79 Slovenko, *Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope*, 23 CATH. U.L. REV. 649 (1974); *Legal Issues in State Mental Health Care: Proposals For Change, supra* note 1, at 339.

physician-patient privilege and its application in a multitude of contexts.[80]

To evaluate the wisdom of a particular privilege one must balance the interests of the relationship sought to be protected through nondisclosure against the interests of the judicial system in obtaining this information. In an effort to advance this analysis Wigmore suggested that any valid privilege should be capable of satisfying four conjunctive conditions:[81]

> (1) The communications must originate in a *confidence* that they will not be disclosed.
>
> (2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
>
> (3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered.*
>
> (4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation.

Wigmore[82] and others[83] have concluded that the physician-patient privilege does not satisfy these requirements. Except in a narrow category of illnesses such as venereal disease, Wigmore hypothesizes, patients do not themselves cloak their illness from the public.[84] The absence of any documented statistical differences in the seeking of medical care either pre- and postenactment of a privilege statute within a jurisdiction or from one privileged to a nonprivileged jurisdiction belies the notion that people are deterred from seeking medical care for fear of judicial disclosure in the absence of a privilege.[85] And, although Wigmore agrees that the physician-patient relationship should be fostered,[86] he concludes that the injury to this relationship occasioned by disclosure does not outweigh the benefit derived from disclosure on the "correct disposal of litigation."[87]

The failure of the general physician-patient privilege to satisfy Wigmore's analytical hurdles[88] has been distinguished insofar as the practice of psychiatry is concerned where, it is argued, Wigmore's four conditions are satisfied.[89]

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80 *E.g.,* Chafee, *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?,* 52 YALE L.J. 607 (1943); Ladd, *A Modern Code of Evidence,* 27 IOWA L. REV. 213 (1942); Long, *The Physician-Patient Privilege Statutes Obstruct Justice,* 25 INS. CO. J. 224 (1958); Morgan, *Suggested Remedies for Obstructions to Expert Testimony by Rules of Evidence,* 10 U. CHI. L. REV. 285 (1944); Purrington, *An Abused Privilege,* 6 COL. L. REV. 388 (1906).

81 8 J. WIGMORE, *supra* note 72, § 2285, at 527.

82 *Id.* § 2380a, at 828.

83 *See* note 80 *supra.*

84 8 J. WIGMORE, *supra* note 72, § 2380a, at 829. Moreover, in this situation a number of states have concluded that the public health requires an exception to the privilege so that the spread of venereal disease might be abated. *Id.*

85 *Id.* at 829-30.

86 *Id.*

87 *Id.* at 527.

88 Wigmore opines that a strong medical lobby and not a more acute analysis of the problem is responsible for the physican-patient privilege statutes in a majority of states. *Id.* at 831.

89 Although Wigmore does not himself undertake an analysis of the privilege as applied to psychiatrists, numerous other commentators have. They have found that psychiatry survives scrutiny under Wigmore's criteria. FED. R. EVID. 504, Adv. Comm. Notes, 56 F.R.D. 183, 242 (1973); Guttmacher & Weihofen,

People will not seek out or be candid with or trust a psychiatrist unless complete confidentiality exists.[90] Unlike the broken arm or ruptured appendix, those conditions for which psychiatric help is sought are often so sensitive and potentially embarrassing that without protection from disclosure the patient will not seek assistance.[91] This personal discomfort is compounded by the stigma society attaches to mental illness.[92] Full disclosure by the patient is an essential ingredient of effective treatment and without a guarantee of nondisclosure, it is argued, this baring of the soul cannot take place.[93] And, even if the necessary information is gained without the necessity of a privilege, the need for patient trust in the psychiatrist is antithetical to any subsequent disclosure.[94] Thus Wigmore's first two criteria for the establishment of a privilege are satisfied. The communications originate in confidence and that confidence is essential to the purposes of the relationship. With regard to Wigmore's third and fourth criteria, the relationship is one which should be fostered and many believe that the harm to the patient and the patient-psychiatrist relationship from judicially compelled revelation is greater than the injury to the judicial process.[95]

If the concept of a psychiatrist-patient privilege is accepted, when does this privilege arise and what exceptions to its application should obtain? More specifically, should it apply in civil commitment proceedings and, if so, to what set of psychiatrist-patient relationships? In those jurisdictions which accord the psychiatrist-patient relationship a privileged status,[96] not all communications

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Privileged Communications Between Psychiatrist and Patient, 28 IND. L.J. 32, 33-35 (1952); Louisell & Sinclair, *Foreword* to *The Supreme Court of California, 1969-1970,* 59 CAL. L. REV. 30, 52 (1971); Slovenko, *Psychiatry and a Second Look at the Medical Privilege,* 6 WAYNE L. REV. 175, 184-94 (1960); *Symposium: Evidentiary Privileges of Non Disclosure,* 33 CONN. B.J. 170, 198 (1959).

90 Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d at 459, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting).

91 M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952); Slovenko, *supra* note 89, at 184.

92 *Developments in the Law, supra* note 1, at 1200.

93 M. GUTTMACHER & H. WEIHOFEN, *supra* note 91, at 270-71; Plaut, *A Perspective on Confidentiality,* 131 AM. J. PSYCH. 1021, 1022 (1974). Although the theoretical appeal of this argument is greater in the context of psychiatry than in the context of the general practice of medicine, the statistical support for its application here is equally deficient. Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma,* 62 CAL. L. REV. 1025, 1034 (1974). No proponent of the psychiatrist-patient privilege has yet to cite a study demonstrating a higher use rate of psychiatrists or a lower incidence of mental illness where that relationship has been accorded a privileged status. *But see* Comment, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Doctrine of Privileged Communications,* 71 YALE L.J. 1226, 1255 (1962), in which a written questionnaire asked participants if they would confide in a psychiatrist if their disclosures would be subject to judicial revelation. The flaw in this study is, *inter alia,* that it focuses respondent's attention on the possibility, if not the probability, of disclosure. Query whether most prospective psychiatric patients contemplate the occurrence of judicial proceedings wherein their disclosure may be relevant and then evaluate the status of the privilege in their jurisdiction prior to making the disclosures. The decision to create a privilege to protect against compelled judicial disclosure should test this critical assumption.

94 17 Cal. 3d at 458, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting).

95 These arguments were favorably received by the drafters of the Federal Rules of Evidence who rejected a general physician-patient privilege but accepted the concept of psychotherapist-patient privilege. Proposed FED. R. EVID. 504, 56 F.R.D. 183, 240 (1973). The rule defines psychotherapist functionally to include a physician and psychologist engaged in the treatment of mental or emotional conditions. The textual discussion does not distinguish application of the privilege where the therapist is a psychologist rather than a psychiatrist because the need for the privilege, or absence thereof, arises not from the therapist's credentials, but from the therapist's function in the relationship.

96 Psychiatrists are included not only within psychiatrist or psychotherapist-patient privilege statutes, but also medical doctors within those privilege statutes applicable to physicians generally. 8 J. WIGMORE, *supra* note 72, § 2382, at 835 n.5.

in all relationships are covered by the privilege.[97] Only where the purposes sought to be obtained by the privilege are present is the information communicated accorded a protected status. Because the primary purpose of the privilege is to encourage candid disclosures to aid in the seeking and receipt of treatment,[98] the first requisite for application of the privilege is that the relationship be established for treatment or for diagnosis in contemplation of immediate treatment.[99] Conversely, where the sole purpose of the relationship is an examination without regard to treatment, for example by an employer's physician as a precondition of employment[100] or by an insurance company's physician to ascertain the insured's health as a precondition to issuance of a policy,[101] confidences are not revealed so that the patient may be effectively treated and the privilege is therefore not applicable.[102] The second condition for the privilege to apply is that the information communicated[103] during the course of the relationship must be necessary for the treatment or diagnosis of the patient.[104] The precise ways in which these general conditions apply to the psychiatrist-patient relationship is analytically complex and must be explored.

a. *Voluntary Treatment*

In the first relationship the patient contacted the therapist on a private outpatient basis whereupon a series of psychotherapeutic encounters occurred. The patient's condition deteriorated and someone then instituted proceedings for commitment. If the psychiatrist is subpoenaed to testify and is questioned about the patient's communications[105] during the therapy session, should a timely objection to such testimony based upon privilege be sustained? Such a scenario would appear to present a paradigm case for application of the privilege if the privilege is recognized in the jurisdiction. The sole purpose of the relationship is treatment and the hypothetical assumes that the communications at issue are essential to that purpose. The answers which have been given to this question, however, are surprising.

One of the earliest voices for according the psychiatrist-patient relation-

97 For a more exhaustive treatment of the general requirements, see C. DEWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT (1958); C. MCCORMICK, HANDBOOK ON THE LAW OF EVIDENCE §§ 98-105 (2d ed. 1972); 8 J. WIGMORE, *supra* note 72, at §§ 2380-2391.

98 Arizona and N.M. Ry. v. Clark, 235 U.S. 669, 677 (1915); C. DEWITT, *supra* note 97, at 25.

99 C. MCCORMICK, *supra* note 97, § 99, at 213.

100 Cherpeski v. Great N. Ry., 128 Minn. 360, 150 N.W. 1091 (1915).

101 Boulignv v. Metropolitan Life Ins. Co., 133 S.W.2d 1094 (Mo. 1939).

102 C. MCCORMICK, *supra* note 97, § 99, at 214.

103 Where the pertinent statute refers to "communications," its coverage may be limited to oral or written expressions that are intended to be communications. Many courts, however, reject such a narrow construction. Where the statute refers to "information," it should be interpreted to include information gleaned through observation and examination as well as oral or written expression intended as communication. *Id.* at 215.

104 *Id.* A variety of factors may defeat the privilege such as the presence of nonessential third parties during the communications. *Id.* at § 101.

105 Whether the psychiatrist is asked the specific content of the patient's statements on a particular topic (*e.g.*, threats to harm himself or another) or his opinion concerning committability which draws upon these statements should be of no moment insofar as the privilege is concerned. In each instance the psychiatrist is called upon to disclose patient communications, in the first situation directly and in the second as translated by the psychiatrist. The cost of inquiring into the accuracy of this translation on cross-examination is direct disclosure.

ship a privileged status was the Group for the Advancement of Psychiatry.[106] Yet the first exception to the psychiatrist-patient privilege the Group ultimately proposed provides:

> *§ 3 Exceptions*
> There is no privilege for any relevant communications under this act
>
> (a) when a psychiatrist, in the course of diagnosis or treatment of the patient, determines that the patient is in need of care and treatment in a hospital for mental illness; . . . .[107]

Since it is unlikely that commitment would be sought when the patient's psychiatrist concludes it is unnecessary, or that the state would call such a psychiatrist as a witness, the proposed privilege is virtually nonexistent in the commitment setting. The decision to except patient communications when relevant to an issue in commitment proceedings was also reached by the drafters of the Model Code of Evidence,[108] the Uniform Rules of Evidence,[109] and the proposed psychotherapist-patient privilege of the Federal Rules of Evidence.[110] Similarly, Arkansas,[111] California,[112] Florida,[113] Kansas,[114] Maine,[115] and Nebraska[116] have adopted versions of the Uniform Federal Rules of Evidence with the same exception to the privilege for civil commitment proceedings. The conclusory justification advanced in favor of this exception is that on balance "the value of preserving confidentiality is outweighed by the interest of society in gaining access to the protected communications."[117]

This legislative trend has been paralleled by judicial opinions holding the privilege inapplicable to civil commitment proceedings even in the absence of an express statutory exception.[118] To reach this conclusion these courts have

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106 Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 175 (1962).

107 *Id.* at 184. A similar exception is contained in the American Psychiatric Association's proposed *Model Law on Confidentiality of Health and Social Service Records*, 136 AM. J. PSYCH. 138, 140 (1979). *See also* CONN. GEN. STAT. § 52-146f(b) (1977); *A State Statute to Provide a Psychotherapist-Patient Privilege*, 4 HARV. J. LEGIS. 307, 321 (1967).

108 MODEL CODE OF EVIDENCE rule 223(2)(a) (1942) provides in part: "(2) There is no privilege under Rule 221 as to any relevant communication between the patient and his physician (a) upon an issue of the patient's condition in an action to commit him or otherwise place him under the control of another . . . ."

109 UNIFORM RULE OF EVIDENCE 503(d)(1) (1974) provides in part: "There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization."

110 FED. R. EVID. 504(D)(1), 56 F.R.D. 183, 241 (1973). The wording of this section is identical to rule 503(d)(1) of the Uniform Rules of Evidence, *supra* note 109.

111 ARK. STAT. ANN. § 28-1001, Rule 503(d)(1) (1979).

112 CAL. EVID. CODE § 1004 (West 1966). The recent decision of the Supreme Court of California in Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20, articulated a psychiatric duty to warn third persons of their patient's threats where the threats are likely to be carried out. Although the patient's therapist in that case did not inform the intended victim of the threat, he did not hesitate to reveal the patient's threats to the police so that the patient might be committed to a mental hospital for observation.

113 FLA. STAT. ANN. § 90.503(4)(a) (West Spec. Pamphlet 1979).

114 KAN. STAT. ANN. § 60-427(c)(1) (1976).

115 ME. R. EVID. 503(e)(1) (Supp. 1978).

116 NEB. REV. STAT. § 27-504(4)(a) (1975).

117 Goldstein & Katz, *supra* note 106, at 186. *See also* Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 635 (1964).

118 Metropolitan Life Ins. Co. v. Ryan, 237 Mo. App. 464, 172 S.W.2d 269 (1943); *In re* Benson, 16 N.Y.S. 111 (1891). *See In re* Fleming, 196 Iowa 639, 641, 195 N.W. 242, 243 (1923). *But see* Suzuki v. Quisenberry, 411 F. Supp. at 1132 n.18; *In re* Sippy, 97 A.2d 455 (D.C. Mun. Ct. App. 1953).

either engaged in attenuated theories of statutory construction[119] or have stated that the treating physician is best qualified, through his knowledge of the patient, to testify in such proceedings and, accordingly, have legislated an exception to the privilege.[120]

Even in the event that information gleaned by the psychiatrist from a therapy session with the patient would be valuable to the court in a commitment proceeding, it should be recognized that the majority of commitments are probably not preceded by such therapy sessions.[121] Courts are, therefore, called upon in the majority of civil commitment proceedings to ascertain committability based upon short-term observation and evaluation along with the public disclosures of the patient. If the information gleaned through the private voluntary psychiatrist-patient relationship is considered to be a predicate to commitment, the validity of the basis of the majority of commitment proceedings is necessarily flawed.

Even if such short-term observation is adequate, however, it should be supplemented with additional psychiatric information when it is available. Assuming that in a given case substantial additional information not available from a nonprivileged source would be revealed, the benefit of disclosure in a single case must be balanced against the perception of a broader class of present or prospective patients who may not engage in therapy or candid disclosures with their therapist based upon a fear of disclosure and subsequent commitment.[122]

The arguments in favor of revelation of confidences in commitment proceedings to protect society from the dangerous mentally ill, to protect the mentally ill from themselves, or to secure needed treatment must assume that commitment will not occur in "appropriate"[123] cases in the absence of such disclosures. The multitude of commitments not preceded by private voluntary therapy between psychiatrist and patient tends to belie this assumption. And, again, to the extent that commitment is avoided in an "appropriate" case because of nondisclosure, the impact of this case must be balanced against the broader impact that this perceived destruction of the privilege may have.

To the extent that nonrevelation may be thought to cause an error in the failure to commit a potentially dangerous mentally ill person, the argument in

119 172 S.W.2d at 273.

120 16 N.Y.S. at 112.

121 The poor are said to suffer from a higher incidence of mental illness than the rest of our society. B. BERELSON & G. STEINER, HUMAN BEHAVIOR: AN INVENTORY OF SCIENTIFIC FINDINGS 639 (1964). They are, therefore, more likely to be subject to commitment proceedings. Because of the high cost of psychotherapy such services have not generally been available to the poor either privately or through governmental programs. *See* A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS (1958); Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to the Patients of Psychiatric Social Workers*, 61 CAL. L. REV. 1050 (1973). It is, therefore, not likely that the majority of commitments are preceded by private psychotherapy. Moreover, it is conceivable that many of those persons who have manifested their trust in the psychotherapist by maintenance of the relationship would accept the psychotherapist's recommendation for in-patient care, thus avoiding the necessity of a commitment proceeding.

122 The argument in favor of the privilege must assume that the "broader class of present or prospective patients" considers the possibility of compelled disclosure, knows the relevant aspects of the law of privilege, correctly applies that law in the situation in which disclosure might be compelled, and chooses not to disclose and receive appropriate care rather than risk the possibility of disclosure. In the absence of valid studies of this aspect of human behavior, only unscientific hunches about the way people would behave in this situation are available to guide our judgment.

123 "Appropriate" is intended to refer only to accuracy under the applicable statutory criteria for commitment.

favor of disclosure fails to take into account certain critical realities. If we rely upon psychiatric predictions of dangerousness to confine the dangerous mentally ill, then we must confront not only the literature canvassing available studies which concludes that psychiatrists are inaccurate predictors of dangerousness[124] but also the express disclaimer of the American Psychiatric Association "that therapists, in the present state of the art, are unable reliably to predict violent acts; their forecasts . . . tend to overpredict violence, and indeed are more often wrong than right."[125] Even if judicial use of these confidences to predict future dangerousness was to be more reliable than psychiatric predictions, the accuracy necessary to justify disclosure is extremely high.[126]

The argument for rejection of the privilege in civil commitment proceedings rests, *inter alia,* upon the assumptions that without this witness' testimony the patient will not secure necessary treatment or will not be prevented from engaging in dangerous behavior. For commitments based upon this first assumption to be justified efficacious treatment must be rendered after commitment. And, if commitments to prevent dangerousness are not to result in permanent exclusion from society, efficacious treatment should also be available for this class of commitments. However, the existing evidence does not support a claim that those committed are effectively treated.[127] Thus, either as a vehicle for reducing dangerousness in society or providing effective treatment to those thought to be in need of it, civil commitment is a weak justification for gutting the privilege.

If efficacious treatment is to ever occur, it must be accompanied by patient cooperation.[128] By definition, this is not present when the patient has rejected treatment but is subjected to it by an order for involuntary commitment. Such cooperation is more likely to occur, if at all, in voluntary treatment. If we wish to foster beneficial treatment, which may have some impact on the reduction of societal dangerousness,[129] where a private voluntary psychiatrist-patient rela-

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124 Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence,* 29 RUTGERS L. REV. 1084 (1976); Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife That Cuts Both Ways,* 2 PSYCH. TODAY 43 (Feb. 1969); Diamond, *The Psychiatric Prediction of Dangerousness,* 123 U. PA. L. REV. 439 (1975); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CAL. L. REV. 693 (1974).

125 17 Cal. 3d at 437-38, 551 P.2d at 344, 131 Cal. Rptr. at 24.

126 *See* Livermore, Malmquist, & Meehl, *On the Justifications for Civil Commitment,* 117 U. PA. L. REV. 75, 84 (1968):

> Assume that one person out of a thousand will kill. Assume also that an exceptionally accurate test is created which differentiates with ninety-five percent effectiveness those who will kill from those who will not. If 100,000 people were tested, out of the 100 who would kill, 95 would be isolated. Unfortunately, out of 99,900 who would not kill, 4,995 people would also be isolated as potential killers. In these circumstances, it is clear that we could not justify incarcerating all 5,090 people. If, in the criminal law, it is better that ten guilty men to go free than that one innocent man suffer, how can we say in the civil commitment area that it is better that fifty-four harmless people be incarcerated lest one dangerous man be free?

127 Schwitzgebel, *The Right to Effective Mental Treatment,* 62 CAL. L. REV. 936, 947-48 (1974).

128 Katz, *The Right to Treatment—An Enchanting Legal Fiction?,* 36 U. CHI. L. REV. 755, 768-69 (1969); Wexler, *Foreword: Mental Health Law and the Movement Towards Voluntary Treatment,* 62 CAL. L. REV. 671 (1974).

129 Statistically, there is no reason to conclude that mentally ill persons as a class are more dangerous than nonmentally ill persons. Diamond, *supra* note 124, at 448; Langsley & Barter, *Community Mental Health in California,* 122 W. J. MED. 271, 272 (1976). Thus, commitment of the mentally ill as a vehicle for reducing the number of dangerous persons in society is likely to have only a limited impact upon societal dangerousness at best, for it operates only upon a distinct minority of those who might engage in such behavior.

tionship has preceded the institution of civil commitment proceedings, that relation should be privileged. Absent an effective waiver of that privilege[130] the psychiatrist should not be examined concerning confidential communications made during the course of that relationship.[131]

b. *Examination*

A situation to be contrasted to the first is where the psychiatrist is appointed by the court to examine the patient and inform the court of his findings. The purpose of this relationship is not treatment and the patient is therefore not encouraged to engage in disclosures which will, from his perspective, result in beneficial treatment. No serious dispute exists that the privilege is inapplicable in this situation.[132] One significant caveat must be advanced here. Since the privilege is for the benefit of the patient, his reasonable belief concerning the purpose of the relationship should control.[133] Accordingly, where the purpose of the interview is other than treatment or diagnosis in contemplation of immediate treatment the patient should be informed by the psychiatrist at the outset of the interview of its purpose.[134] Failure of the psychiatrist to announce this purpose could provide a basis to reject automatically the psychiatrist's testimony[135] or to shift to the proponent of such evidence the burden of proving that treatment could not reasonably have been contemplated by the patient.[136]

c. *Involuntary Treatment*

Suppose the patient has been receiving involuntary treatment. The commitment order has either expired[137] or the patient has exercised his right to seek

130 *See* C. McCormick, *supra* note 97, § 103.

131 411 F. Supp. at 1132 n.18; Orland, *Evidence in Psychiatric Settings,* 11 Gonzaga L. Rev. 665, 679 (1976). Professor Orland points out that the delegation of authority to the psychotherapist to determine that hospitalization is necessary in the proposed federal psychotherapist-patient privilege, thereby excepting the privilege, is likely to destroy the relationship and not render damage to it unlikely. *Id.* at 678.

132 *E.g.,* State v. Fouquette, 67 Nev. 505, 221 P.2d 404 (1950).

133 *See* cases cited at note 99 *supra.* The application of this test could be problematic in the context of a pre-commitment examination.

134 From the psychiatrist's perspective such a warning has been said to constitute an ethical obligation. Halleck, Psychiatry and the Dilemma of Crime 329 (1967); J. McDonald, Psychiatry and the Criminal 40 (1958). *See also Report of the Task Force on the Role of Psychology in the Criminal Justice System,* 33 Am. Psychologist 1099, 1102 (1978).

135 *See* Commonwealth v. Lamb, 365 Mass. 265, 267, 311 N.E.2d 47, 49 (1974).

136 Where the exclusion of evidence on grounds of privilege is at issue, the person claiming the existence of the privilege normally bears the burden of persuading the court of the existence of the privilege. United States v. Palmer, 536 F.2d 1278, 1281 (9th Cir. 1976). Shifting this burden where no warning was given would be an appropriate vehicle to reflect a policy favoring clear communication in the purpose of the relationship. *See* Cleary, *Presuming and Presumptions: An Essay on Juristic Immaturity,* 12 Stan. L. Rev. 5 (1959).

137 On legal and therapeutic grounds, commitments of finite duration appear to be required. D. Wexler, Criminal Commitments and Dangerous Mental Patients: Issues of Treatment and Release 18-32 (1976); Shah, *Some Interactions of Law and Mental Health in Handling of Social Deviance,* 23 Cath. U.L. Rev. 674, 694 (1974). Presently, many states limit the duration of commitments and require subsequent judicial proceeding for further confinement. *Developments in the Law, supra* note 1, at 1383.

No doubt Justice Stewart's observation in *O'Connor v. Donaldson,* in the course of affirming Mr. Donaldson's award of damages in a civil rights action, will prompt further attention to this issue: "Nor is it enough that Donaldson's original confinement was founded upon a constitutionally adequate basis, if in fact it was, because even if his involuntary confinement was initially permissible it could not constitutionally continue after that basis no longer existed." 422 U.S. at 574-75.

judicial review of his commitment.[138] In such situations, the psychiatrist's relationship with the patient is not exclusively for the purpose of treatment. Because of the psychiatrist's role in the commitment process, therapeutic and forensic contacts are intertwined. Should the psychiatrist be permitted to testify over a timely objection on the grounds of psychotherapist-patient privilege?

If the privilege should not apply in the first situation involving voluntary outpatient treatment prior to the institution of proceedings, then the present situation does not call for application of the privilege. However, if the institution of commitment proceedings should not automatically result in loss of the privilege, far more difficult questions are presented.

Those considerations which favor disclosure in this context are: (1) the bulk of therapy in public mental institutions is delivered by persons whose relationship with the patient is not covered by a privilege; (2) if psychiatrist-patient therapy is conducted, a court order for involuntary commitment and not a pledge of confidentiality was responsible for thrusting the patient into this relationship; (3) whether or not a privilege is accorded, the involuntary patient is not likely to make disclosures unless he thinks it will lead to his release; and (4) whether or not a privilege is accorded, treatment of the involuntary patient is not likely to be effective.

The considerations which favor confidentiality are: (1) confidentiality is necessary for effective treatment, and (2) all institutional patients whether nonpaying or involuntary are entitled to effective treatment. Because the source of the privilege is not a contractual relationship between the psychiatrist and patient but the desire to encourage confidentiality,[139] most courts which have addressed the application of the privilege to nonpaying residents of public mental institutions have recognized that patients should not, for that reason alone, be deprived of the privilege.[140] Similarly, if treatment for the involuntary patient is contemplated, confidentiality would seem as important as for the voluntary patient.[141]

For the bulk of persons involuntarily committed to public mental institutions, regular psychiatrist-patient therapy sessions do not exist.[142] Therapy ses-

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138 *Developments in the Law, supra* note 1, at 1383.

139 Linscott v. Hughbanks, 140 Kan. 353, 361-64, 37 P.2d 26, 31-32 (1934); State v. Fontana, 277 Minn. 286, 288-89, 152 N.W.2d 503, 505 (1967).

140 *E.g.,* Taylor v. United States, 222 F.2d 398 (D.C. Cir. 1955); State v. Shaw, 106 Ariz. 103, 106, 471 P.2d 715, 718 (1970), *cert. denied,* 400 U.S. 1009 (1971); Linscott v. Hughbanks, 140 Kan. 353, 361-64, 37 P.2d 26, 31-32 (1934); State v. Fontana, 277 Minn. 286, 288-89, 152 N.W.2d 503, 505 (1967); State v. Sullivan, 373 P.2d 474, 479 (Wash. 1962).

141 To the extent that confidentiality is the necessary lubricant for the closed mouth, those patients who have not chosen therapy but who have had it chosen for them by the court would seem to require greater lubrication to reveal information which could lead to a greater detriment—continued involuntary hospitalization. This rationale seems to underlie the decisions in *Taylor v. United States,* and *State v. Shaw.*

142 In contrast with the previous representations of the psychiatric profession, "[p]resumably all of the patients in any good mental hospital are receiving psychiatric treatment. This is true of persons whether they are sent to St. Elizabeths Hospital as civil insane, as criminal insane or as 'sexual psychopaths.' " 222 F.2d at 401 (quoting Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital). An American Bar Foundation Study of psychiatric hospitalization found active treatment being undertaken with no more than "10 to 15 percent of the total patient population." R. ROCK, M. JACOBSON, & R. JANOPAUL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 70 (1968). Much of this is based upon the relatively low numbers of psychiatrists on staff at such facilities. Of those psychiatrists present, a large percentage are foreign medical graduates with "only a halting command of the language of their patients and an even dimmer understanding of the communities to which their patients will return." Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives,* 70 MICH. L. REV. 1107, 1126 (1972).

sions, if existent, are conducted by psychiatric social workers[143] and other persons to whom the privilege does not apply.[144] Thus, regardless of the utility of such therapy, the patient ordinarily enjoys no privilege to prevent judicial disclosures of the communication made in this relationship. The failure of an effective psychiatrist-patient relationship cannot therefore be blamed upon the absence of a privilege but, in the first instance, upon the absence of sufficient numbers of psychiatrists in public institutions.

Proponents of the psychiatrist-patient privilege contend that the first purpose of the privilege is to induce the patient to seek psychiatric care.[145] By definition the involuntarily committed patient has rejected voluntary psychiatric care.[146] Judicial compulsion and not a pledge of confidentiality led to the patient's presence in the hospital. The involuntarily committed patient would be present at the hospital whether or not a privilege existed.

The second purpose of the privilege is encouragement of candid disclosures necessary for effective therapy.[147] The information currently available seriously questions the efficacy of therapy currently available for the civilly committed patient.[148] Accordingly, the second purpose to be served by the privilege seems ill served in this context regardless of the privilege's application.

The third purpose of the privilege is the development of patient trust.[149] The therapist must not pose a threat to the patient. Thus, from the beginnings of contemporary psychotherapy, it has been suggested that a psychiatrist should have no control over the patient.[150] Involuntary commitment is itself

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143 Psychiatric social workers are the mainstay of the staffs of most public mental health facilities. Comment, *supra* note 121. *See also* Slovenko, *supra* note 79, at 664.

144 Because the psychotherapist privilege statutes are usually drafted to include only psychiatrists or psychologists, care rendered directly by psychiatric social workers, nurses, aides, and others is normally not included with the privilege. Slovenko, *supra* note 79. The therapeutic session may also be conducted as a group which lowers the per patient cost of service; however, the presence of the other patient-participants is normally thought sufficient to defeat the privilege. Cross, *Privileged Communications Between Participants and Group Psychotherapy*, 1970 L. & Soc. Order 191, 193-94.

145 17 Cal. 3d at 458-59, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting).

146 This generalization assumes that the patient is competent and that the hospital would accept the patient's application for voluntary admission if tendered. Restrictions on the use of guardianship proceedings as an alternate route to hospitalization suggest that increasing numbers of committed patients will lack the legal capacity to make application for voluntary admission. *See, e.g.*, Pima County Pub. Fiduciary v. Superior Court, 26 Ariz. App. 85, 546 P.2d 354 (1976). Additionally, in the case of the fickle patient who wishes to be a voluntary patient one day and to leave the next, yet in the hospital's opinion requires treatment and meets the standards for involuntary hospitalization, the hospital may opt to reject the voluntary application and seek commitment.

147 17 Cal. 3d at 459-60, 551 P.2d at 359, 131 Cal. Rptr. at 39.

148 Schwitzgebel, *supra* note 127, at 947-48:

> In summary, the traditional forms of psychoanalytic psychotherapy as generally practiced in public hospitals tend to show very limited effects upon behavior when patients are considered in the aggregate. . . . The effectiveness of traditional therapies in changing the behaviors which led to the commitment of the patients has yet to be clearly demonstrated. In a sense, these traditional forms of therapy have been living for many years on public faith and "credit" while the public, legislatures, and courts have acted in reliance upon statements of therapists which indicate that treatment can in fact change behavior.

149 17 Cal. 3d at 459-60, 551 P.2d at 359, 131 Cal. Rptr. at 39.

150 Plaut, *supra* note 93, at 1022:

> The principle of the inverse relationship between confidentiality and authority was long ago realized by psychoanalysts from another perspective. It was apparent in analysis that full disclosure by the patient (via free association) was possible only if the analyst had no "authority" over the patient's life . . . .

See also Dubey, *Confidentiality as a Requirement for the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*, 131 Am. J. Psych. 1093, 1094 (1974).

antithetical to this tenet of effective psychotherapy. The psychiatrist's role in recommending commitment or release and in testifying in court leads to patient perceptions of the institutional psychiatrist as a jailer, not a healer.[151] So long as involuntary commitment continues and the patient's psychiatrist participates in that decision-making process patients are not likely to trust their psychiatrist with any information except that which they believe will expedite their release.[152]

Involuntary commitment is intertwined with the judicial process and, for the present, the judicial role in this process is likely to increase rather than decrease. Predictably hospitals to which patients are involuntarily committed will be called upon with increasing frequency to justify continued involuntary hospitalization. Given the predictability of this occurrence and the substantial failure of the privilege's purpose in this context, the argument in favor of applying the privilege here is too weak to overcome the need for probative evidence.

This conclusion is based upon the assumption of a single hospital unit which examines, treats, and testifies. An alternative response is the use of separate treating and examining teams within the hospital. This approach would permit treating psychiatrists to approach their tasks without divided loyalties. Their opinion concerning commitment would not be sought or accepted by the hospital.[153] The notes of their discussions with the patient could be eliminated from the patient's chart.[154] Once patients came to realize the treating psychiatrists' role, candid disclosures might increase. And, the arguments in favor of according a privileged status to this relationship would be strengthened.

2. The Right to Privacy

The application of psychotherapist-patient privilege in the commitment setting depends, in the first instance, upon the willingness of the legislature to enact such a privilege.[155] In the absence of such legislation, an alternative source of the same protection may be an expansion of a constitutional right to privacy. Proponents of this position contend that the constitutional protection for the right to privacy found in the penumbras of the constitution and recognized by the Court in such decisions as *Griswold v. Connecticut*[156] and *Roe v.*

151 Prettyman, *The Indeterminate Sentence and the Right to Treatment,* 11 AM. CR. L. REV. 7, 19 (1972). *See also* T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 230 (1963); Fleming & Maximov, *supra* note 93, at 1045-46.
152 Prettyman, *supra* note 151, at 28.
153 Because of the hospital's critical role in the recommitment or judicial review process, this change could be accomplished by the hospital without the necessity of legislative action. Simply by arranging with the prosecutor to call only the examining team psychiatrists, the hospital could circumvent the privilege problems. Should legislative change be necessary because, for example, the prosecutor persists in issuing subpoenas for the treating physicians, this separation of functions offers the legislature the opportunity to encourage therapeutic relationships while still avoiding inappropriate release.
154 Although most courts conclude that the recordation of a privileged communication does not result in the loss of its privileged status merely because it is placed in the patient's medical record, patient knowledge of this enhanced degree of secrecy could lead to greater trust. 8 J. WIGMORE, *supra* note 72, § 2382, at 839 n.10.
155 *See* cases cited at note 76 *supra.*
156 381 U.S. 479 (1965).

Wade[157] is broad enough to include psychotherapist-patient relationships.[158] Although the theoretical constructs for such an argument exist,[159] its judicial reception has been lukewarm.[160]

The argument in favor of the right to privacy protecting the psychotherapist-patient relationship is strongest when the patient has consulted the psychotherapist for treatment and commitment proceedings arise subsequently in which this psychotherapist's testimony is judicially compelled. Unlike communication with an institutional psychiatrist after the inception of commitment proceedings, it is reasonable to assume that the patient in the first relationship does not expect disclosure. Such a compelled revelation of the patient's innermost thoughts results in governmental intrusion upon the patient's ability to limit disclosure of his private affairs, and this is part of the meaning of the right to privacy.[161]

Although the Supreme Court found that the relationship between a pregnant woman considering termination of her pregnancy and her physician fell within the constitutional zone of privacy,[162] it is clear that not all doctor-patient relationships are included within this constitutional ambit.[163] Is the relationship between the treating psychotherapist and his patient of the same or greater importance than other private activities relating to marriage,[164] procreation,[165] contraception,[166] and abortion[167] where the Court has previously grounded limitations upon governmental intrusion? The questions which are brought to the psychotherapist include problems arising out of these activities and may bear directly on the quality or future existence of the patient's life. A convincing argument may therefore be advanced for protecting the communications made within the relationship from compelled judicial disclosure.

However, even if this relationship is protected by a constitutional right to privacy, the right will not be unqualified,[168] and its assertion in a particular

157 410 U.S. 113 (1973).

158 This argument was advanced in Whalen v. Roe, 429 U.S. 589 (1977); Felber v. Foote, 321 F. Supp. 85, 88-89 (D. Conn. 1970); *In re* Lifshutz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970); Bremer v. State, 18 Md. App. 291, 307 A.2d 503 (1973), *cert. denied,* 415 U.S. 930 (1974).

159 *E.g.,* Roe v. Ingraham, 403 F. Supp. 931, 935-38 (S.D.N.Y. 1975), *rev'd sub nom.* Whalen v. Roe, 429 U.S. 589 (1977). *See* Krattenmaker, *Testimonial Privileges in Federal Courts: An Alternative to the Proposed Federal Rules of Evidence,* 62 GEO. L. J. 61, 94-100 (1973); Louisell, *supra* note 71, at 110-11.

160 Felber v. Foote, 312 F. Supp. at 88-89; *In re* Lifshutz, 2 Cal. 3d at 431, 467 P.2d at 567, 85 Cal. Rptr. at 839; Bremer v. State, 18 Md. App. at 334, 307 A.2d at 529. The decision of the California Supreme Court in *Lifschutz* acknowledged that the psychiatrist-patient privilege "has deeper roots than the California statute and draws sustenance from our constitutional heritage," but nonetheless concluded that the state's interest in ascertaining the truth in litigation, particularly in the case of the patient-litigant, outweighed whatever confidentiality may be constitutionally compelled. 2 Cal. 3d at 431, 467 P.2d at 567, 85 Cal. Rptr. at 839.

Similarly, Justice Steven's opinion in Whalen v. Roe, 429 U.S. 589 (1977), upholding a New York law which required state computer storage of physician prescriptions for certain classes of drugs, does not deny that the physician-patient relationship may be of constitutional dimension. Rather it concludes that the New York statutory scheme did not rise to a level of intrusion sufficient to establish an invasion of whatever privacy interest may exist.

161 429 U.S. at 599.

162 410 U.S. 113.

163 429 U.S. 589.

164 Loving v. Virginia, 388 U.S. 1 (1967).

165 Skinner v. Oklahoma, 316 U.S. 535 (1942).

166 Eisenstadt v. Baird, 405 U.S. 438 (1972).

167 410 U.S. 113.

168 *Id.* at 154.

context must be balanced against the state interests implicated.[169] In the commitment hearing, the state's interests against which the right to privacy must be balanced include protection of the public from the dangerous mentally ill, protection of the mentally ill from self-inflicted harm, and beneficial treatment for the proposed patient. Thus, to require the patient's therapist to testify over a timely and specific objection it must be decided that these state interests are sufficiently compelling[170] to justify denigration of the patient's privacy.

The analysis which should be undertaken to resolve this should focus first on the compelling nature of the state's interest. Second, the analysis should focus upon the necessity for the use of these psychotherapist-patient communications to achieve the goals of the state. Assuming that the state's interests in commitment are compelling,[171] the question is whether judicial revelation of these psychotherapist-patient communications is necessary for the state to be successful in committing a person. If most commitments are not preceded by psychotherapy,[172] then the use of information gleaned from psychotherapy cannot be justified by a compelling state interest.

This same result does not follow where the relationship in question is with an examining psychiatrist or institutional psychiatrist treating an involuntary patient. In these relationships it cannot reasonably be concluded that privacy is to be expected. Here the direct or indirect object of the relationship is ordinarily disclosed so that the hospital or court may decide whether commitment is appropriate.

3. The Privilege Against Self-Incrimination

In the absence of a psychotherapist-patient privilege or of a constitutional right to privacy, another potential limitation on the use of psychotherapist-patient communications in civil commitment proceedings is the constitutional privilege against self-incrimination. The argument in favor of applying the privilege against self-incrimination in the commitment process recites that, regardless of the civil label attached to such proceedings, commitment results in a deprivation of liberty which should not be based upon the compelled testimony of the prospective patient.[173] According to this argument the use of evidence acquired through psychiatric or other staff interviews should not be admissible in a civil commitment proceeding unless the patient has waived the protection of the privilege against self-incrimination.

The acceptance or rejection of this argument poses one of the most troublesome problems in judicial scrutiny of civil commitment procedures. In

169 *See, e.g.,* Schachter v. Whalen, 581 F.2d 35 (2d Cir. 1978), holding that the intrusion into the privacy of patient records occasioned by the subpoena of such records by a state medical licensing board was permissible in light of the state's interest in investigating medical misconduct.

170 The recognition of a right to privacy reflects a judicial judgment that certain "fundamental rights" are involved, thereby requiring the stricter degree of scrutiny of the compelling state interest test. 410 U.S. at 153-56.

171 Although the Court has concluded that *parens patriae* and police power commitments are legitimate exercises of a state's powers, it has not yet addressed the question of whether such commitments advance a compelling state interest. 99 S. Ct. 1804.

172 *See* note 121 *supra.*

173 Aronson, *Should the Privilege Against Self-Incrimination Apply to Compelled Psychiatric Examinations,* 26 Stan. L. Rev. 55, 79-80 (1973); *Developments in the Law, supra* note 1, at 1303; *Legal Issues in State Mental Health Care: Proposals for Change, supra* note 1, at 101.

addition to the conceptual legal problems posed by this question, the practical consequences starkly define the issues. Application of the privilege may result in the rejection of needed treatment. Conversely, denial of the privilege may result in the evidence supporting a lengthy involuntary confinement flowing exclusively from the prospective patient's compelled statements. Before probing more deeply into the constitutional supports for the arguments, an appreciation of the complexity of this issue may be advanced by assuming that the protection against self-incrimination is applicable and by examining its application in the commitment process.

The privilege against self-incrimination is a limitation on the authority of the sovereign and not on private citizens.[174] Thus a statement made to a private psychiatrist prior to the institution of commitment proceedings would be without the protection of the privilege against self-incrimination just as a criminal defendant's admission of guilt to a private citizen not associated with a law enforcement agency would be without the privilege. No governmental compulsion is present in either case. The same absence of governmental compulsion exists where the statements were made while the patient was a voluntary[175] inpatient at a public or private[176] psychiatric hospital. When the basis for hospitalization becomes involuntary, the element of governmental compulsion enters into the equation.

At what point in time can the patient's status be considered sufficiently involuntary to require consideration of the privilege? Arguably the application of the privilege can be considered once a petition for involuntary commitment has been filed, but can it be considered at any time before that? What, for example, of the voluntary inpatient who is required to give twenty-four hours notice of his intention to leave?[177] The recognition of a cause of action against such a facility for the consequences of an inappropriate discharge[178] mandates that the prudent hospital develop procedures to review the discharge.[179] If the patient is examined at this time to evaluate the propriety of involuntary proceedings, should the privilege apply? To the extent that deprivation of a criminal suspect's freedom of action in some significant manner triggers application of the privilege,[180] the nature of the voluntary patient's confinement becomes involuntary or custodial once the request for discharge has been made and not

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174 *E.g.*, United States v. Solomon, 509 F.2d 863, 867-71 (2nd Cir. 1975); United States v. Bolden, 461 F.2d 998, 999 (8th Cir. 1972); United States v. Fioravanti, 412 F.2d 407, 413 (3d Cir. 1969).

175 Where, however, voluntary hospitalization is, for example, plea bargained for dismissal of a petition for involuntary hospitalization, the element of government compulsion increases. *See also* note 65 *supra*.

176 So long as the private psychiatric hospital detains patients involuntarily pursuant to state law, the hospital's relationship with the patient is not merely determined on the basis of a private contract but also on the basis of a public delegation of authority to the hospital to act as an agent of the state. To that extent the application of the privilege against self-incrimination to a patient involuntarily confined pursuant to a state commitment statute in a private psychiatric hospital depends on the same considerations which apply in the public facility.

177 *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-519(B) (1974), which provides that a voluntary patient shall be discharged within twenty-four hours of a request for discharge unless within that time proceedings for involuntary commitment are authorized.

178 *See, e.g.*, Fair v. United States, 234 F.2d 288 (5th Cir. 1956); Austin W. Jones Co. v. State, 122 Me. 214, 119 A. 577 (1923). *But see* Kravitz v. State, 8 Cal. App. 3d 301, 87 Cal. Rptr. 352 (1970).

179 Conversely, the recognition of a cause of action for inappropriate confinement dictates that overprediction will not be judicially tolerated either. 422 U.S. at 574-75.

180 Miranda v. Arizona, 384 U.S. 436, 477 (1966). *See also* Mathis v. United States, 391 U.S. 1, 5 (1967), holding that *Miranda*'s warning requirement is triggered by custody unrelated to the case under investigation.

immediately satisfied. Accordingly, the privilege should apply here, if it is to apply at all in the context of civil commitment. Similarly, the lack of freedom to leave the hospital following an order for temporary hospitalization for an initial examination prior to commitment or following an order of commitment would call for application of the privilege against self-incrimination. Additional analysis of the problem of which stages of the commitment process to which the privilege should apply would similarly profit by analogy to the privilege's application in the criminal process.

Assuming that the privilege against self-incrimination does apply during a particular hospitalization, to what settings during the hospitalization is the privilege and its concomitant requirement of a warning applicable? Questioning of the patient by hospital staff on such matters as biographical data does not, by analogy to the criminal law, invoke the privilege against self-incrimination.[181] However, certain distinctions in the scope of information relevant to a prospective patient as compared with a criminal defendant's guilt or innocence make this analogy problematic. A psychiatric patient's hostility during an interview designed to glean biographical information may be interpreted as a manifestation of a particular mental illness. An inability to respond to a question may be interpreted as an absence of orientation consistent with a mental illness. Many things which seem logically unrelated to a diagnosis of mental illness are considered to be important pieces of psychiatric data.[182] Unlike the scope of relevance in criminal proceedings, the potential in commitment proceedings exists for virtually all information about the patient to bear upon the patient's mental condition and therefore constitute the basis for commitment. An examination may generate independent new evidence to support the commitment in addition to whatever preceded the initial order for confinement or observation. Thus it might be contended that whenever the involuntary patient's response to any staff questions constitutes a partial foundation[183] for commitment, such evidence may not be received in the absence of a valid waiver of the privilege.

This possibility is troubling for numerous reasons. At the time of the staff-patient communication it may not be certain that a subsequent commitment proceeding will occur and that the results of this conversation may be utilized in support of commitment. If the staff member is to preserve the potential for admissibility of the patient's statement, he must provide the necessary warning in timely fashion. If we assume that patients are not ordinarily inclined to communicate information which they conclude may lead to continued confinement, a warning preceding each interchange seems likely to sever communica-

181 United States *ex rel.* Hines v. Lavallee, 521 F.2d 1109, 1113 (2d Cir. 1975), *cert. denied*, 423 U.S. 1090 (1976). Note that where commitment is grounded upon the patient's inability to provide for his basic necessities (*i.e.*, passive danger to self), questions concerning the patient's employment history, wages, or residence could fall within the protection.

182 "All of the psychiatrists' professional education has been directed toward the development of a fluid, amorphous, sentient comprehension of the inner life of his patient. Every tiny portion of information communicated to him becomes an integral part of this comprehension . . . ." Diamond & Louisell, *The Psychiatrist as an Expert Witness: Some Ruminations and Speculations*, 63 MICH. L. REV. 1335, 1351 (1965). *See also* M. GUTTMACHER & H. WEIHOFEN, *supra* note 91, at 279.

183 Such statements may constitute a potential foundation for commitment where they are expressly recited in the evidence or where they form part of the basis of an opinion of the patient's condition. *See* text accompanying notes 309-30 *infra*.

tions completely. Beyond this threshold problem three more exist: (1) the formulation of an appropriate warning, (2) the difficulty of evaluating patient waivers, and (3) the accessibility to proof when the privilege is not waived. The privilege against self-incrimination is not a rule of competency beyond the power of a party to waive but a right to refuse to give evidence which can be waived. This requires that the existence of the privilege against self-incrimination and the potential for its waiver be communicated to the patient.

What form should the warning take? Several possibilities exist: a formal *Miranda*[184] warning, an informal warning ("Your responses to my questions may be used at your commitment hearing. . . ."), or no set warning leaving the precise communication to the skills of the staff member communicating with the particular patient. If the similarity between criminal and civil commitment proceeding is sufficient to compel application of the privilege against self-incrimination, the patient's mental condition should bear upon waiver and not upon the formulation of the necessary warning. Yet a patient's particular condition may suggest that if the warning is to be understood it should be tailored to his frame of reference. This would necessitate individualized warnings which raises the problem of evaluating the sufficiency of the warning communicated in each case.

More troublesome than the formulation of the warning is the evaluation of purported waivers. The traditional "intentional relinquishment of a known right"[185] test for evaluating such waivers is likely to be difficult to apply in this context. Although prior to commitment one might wish to assume competency thereby justifying the acceptance of a patient's waiver at face value,[186] the very purpose and nature of these proceedings question the logic of this assumption.[187] Following a commitment, even in the absence of a specific finding of incompetency, the acceptance of patient waivers can be accomplished with even lesser confidence. And, to confound matters further, if any staff questioning which may lead to evidence upon which an order of commitment is based necessitates a warning and waiver, precise gauges of competency on a daily if not hourly basis may be required as a condition precedent to admission of such evidence.

The *Lessard* court's response to this problem is less than satisfactory. In a footnote to a textual reference that a commitment may not rest upon a patient's statements to the psychiatrist "in the absence of a showing that the statements were made with 'knowledge' that the individual was not obliged to speak,"[188] the court noted:

> We use the term knowledge advisedly. The presumption in a civil commitment proceeding must be that the individual is indeed competent. If his rights are explained to him in simple terms it may be presumed that he has the requisite knowledge. If the individual in fact does not have this knowledge because of a mental illness a subsequent finding of mental illness or mental incapacity on the basis of his statements cannot be said to violate due process.

184 384 U.S. 436.
185 *Id.* at 475; Johnson v. Zerbst, 304 U.S. 458, 464 (1938).
186 Lessard v. Schmidt, 349 F. Supp. at 1101 n.33.
187 *See* Pate v. Robinson, 383 U.S. 375, 384 (1966).
188 349 F. Supp. at 1101.

> The state will still be obliged to prove that he is dangerous in order to sustain a recommendation of commitment.[189]

The function which a "presumption of competence" or sanity plays in a civil commitment proceeding is to require that the state satisfy its burden of persuasion based only upon the evidence adduced at the hearing pursuant to the rules of evidence. This purpose is inapposite to the question of the competency of the proposed patient to waive particular rights in such a proceeding where all available information should be considered by the judge.[190] On such issues the court should consider any prehearing psychiatric examinations. Particularly in a jurisdiction in which prehearing examination reports indicating an absence of the requisite degree of mental disorder would result in a dismissal of the proceedings without the necessity of a hearing,[191] the existence of the hearing itself is cause for extremely stringent scrutiny of any purported waiver.

Perhaps it is the likelihood that few of such waivers could survive careful scrutiny which then led the *Lessard* court into a fundamental mistake. The fourth and fifth sentences of *Lessard*'s footnote thirty-three envelop the extension of the privilege to civil commitment proceedings by concluding that regardless of the patient's competence any purported waiver of the privilege is constitutionally adequate. This approach is inadequate. If the privilege is applicable, in the absence of a knowing and intelligent waiver of the privilege the result of staff inquiries of the patient should not provide the foundation for an order of commitment.

To consider further the impact of applying the privilege we must assume that a patient refuses to waive the privilege. How will the state now seek to prove that the proposed patient meets the statutory criteria for commitment? The essential question in commitment proceedings is the proposed patient's mental health, and the prime source of this information is the proposed patient. Without an examination of this person it is highly questionable whether the state can sustain its case if a rigorous standard of persuasion is applied.

The argument supporting application of the privilege in civil commitment proceedings must rest upon the assumption that civil commitments are sufficiently similar to criminal cases as to dispense with the civil label[192] or that regardless of the fifth amendment, a similar limitation on governmental compulsion is contained in the due process clause of the fourteenth amendment.[193] The first argument relies heavily on the Supreme Court's decision in *In re Gault*[194] which held that, notwithstanding the civil label, the fifth amendment privilege against self-incrimination applied in juvenile proceedings. Disregarding labels, the Court focused upon the involuntary confinement resulting from compelled statements.[195] By analogy, civil commitment of the mentally ill

189 *Id.* at n.33.

190 The validity of the purported waiver is a preliminary question concerning the admissibility of evidence to be decided by the trial judge who is not bound by the rules of evidence, except as to matters of privilege, in making this determination. FED. R. EVID. 104(a).

191 Wexler & Scoville, *supra* note 15, at 63.

192 *Developments in the Law, supra* note 1, at 1303.

193 *Id.*

194 387 U.S. 1, 49-50 (1967).

195 *Id.*

is also "incarceration against one's will."[196] Accordingly, a strong argument for application of the privilege against self-incrimination may be advanced on this ground. A number of courts have found this argument persuasive and have adopted the privilege against self-incrimination in civil commitment on this basis.[197]

This response has not, however, been unanimous. The majority of courts[198] and commentators[199] who have addressed this issue have rejected the application of the privilege against self-incrimination in civil commitment proceedings. Some have simply adhered to the civil label attached to such commitments and distinguished the privilege on that basis.[200] Although this approach appears inconsistent with the analysis required by *Gault,* there is reason to question *Gault*'s continued viability on this issue.

The reasoning used by Chief Justice Burger in deciding what standard of persuasion should apply in civil commitment proceedings recites that "[i]n a civil commitment state power is not excercised in a punitive sense. Unlike the delinquency proceeding in *Winship,* a civil commitment proceeding can in no sense be equated to a criminal prosecution."[201] These statements are troubling. In *Gault,*[202] the Court recognized that the state did not intend to punish but to treat the juvenile.[203] Nonetheless, the Court concluded that the potential length of Gault's involuntary confinement—six years as a juvenile versus two months, if he had been charged with the same act as an adult,[204] and the place of that treatment—"an institution of confinement"[205] constituted a serious deprivation of liberty. The court then reasoned that the constitutional protection against compelled testimony does not turn upon the labels applied to proceedings by the state but the consequences of the proceedings; in that case that Court concluded that juvenile "commitment to a state institution, must be regarded as 'criminal' for purposes of the privilege against self-incrimination."[206]

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196 *Id.* at 50.

197 *E.g.,* Suzuki v. Quisenberry, 411 F. Supp. at 1130-32; Lynch v. Baxley, 386 F. Supp. at 394; Lessard v. Schmidt, 349 F. Supp. at 1110. *See also* McNeil v. Director, Patuxent Inst., 407 U.S. 245, 250 (1972) (Douglas, J., concurring).

In addition, by statute, several states now apply some formulation of the privilege against self-incrimination in civil commitment proceedings. ALA. CODE § 22-52-9(2) (Cum. Supp. 1978); DEL. CODE ANN. § 16-5006(4) (1978 Cum. Supp.); HAWAII REV. STAT. § 334-60(b)(4)(G) (1978); MONT. REV. CODES ANN. § 38-1304(4)(e) (1977 Cum. Supp.); OHIO REV. CODE ANN. § 5122.15(A)(12) (Page Supp. 1978); W. VA. CODE § 27-5-4(c) (1978); WIS. STAT. ANN. § 51.20(6) (Supp. 1978).

198 Gomes v. Gaughan, 471 F.2d 794 (1st Cir. 1973); Tippett v. State of Md., 436 F.2d 1153, 1162 (4th Cir. 1971) (Sobeloff, J., concurring and dissenting), *cert. dismissed,* 407 U.S. 355 (1972); French v. Blackburn, 428 F. Supp. 1351, 1359 (M.D.N.C. 1977); Cramer v. Tyars, 23 Cal. 3d 131, 588 P.2d 793, 151 Cal. Rptr. 653 (1979); *In re* Beverly, 342 So.2d 481, 488 (Fla. 1977); People v. Fuller, 24 N.Y.2d 292, 248 N.E.2d 17, 21 (1969); State v. O'Neil, 274 Or. 59, 545 P.2d 97 (1976); Hawks v. Lazaro, 202 S.E.2d 109 (W. Va. 1974).

199 M. GUTTMACHER & H. WEIHOFEN, *supra* note 91, at 285; Orland, *supra* note 131, at 686; *Developments in the Law, supra* note 1, at 1312. *But see* Fielding, *Compulsory Psychiatric Examination in Civil Commitment and the Privilege Against Self-Incrimination,* 9 GONZAGA L. REV. 117, 167 (1973); Note, *Application of the Fifth Amendment Privilege Against Self-Incrimination to the Civil Commitment Proceeding,* 1973 DUKE L.J. 729.

200 *In re* Beverly, 342 So.2d at 488; State v. O'Neil, 274 Or. at 66, 545 P.2d at 104.

201 99 S. Ct. at 1810 (footnote omitted).

202 387 U.S. 1.

203 *Id.* at 15-16.

204 *Id.* at 29.

205 *Id.* at 27.

206 *Id.* at 49.

The underlying act for which Addington was indefinitely committed, assault by threat[207] is a misdemeanor punishable by a maximum of one year in jail plus a two-thousand-dollar fine.[208] Under the authority of the indefinite commitment he may be confined for the rest of his life. His liberty will be restrained regardless of the state's "civil labels and good intentions." Not only does the potential deprivation vastly exceed that of Gault's but the likelihood of successful treatment is insubstantial. The fact that Addington's three previous hospitalizations did not obviate the need for further hospitalization, the implicit conclusion that Addington's prognosis is not good, and the absence of evidence that involuntary treatment is effective yield the conclusion that Addington may be subject to a lifetime of custodial confinement. If *Gault* cannot be distinguished on this basis, *Addington* represents an erosion of *Gault*'s analytical model. With this erosion of *Gault*, the due process argument for application of the privilege against self-incrimination is seriously undermined.

Other courts have seized upon the distinction between real and testimonial evidence[209] to reject the application of the privilege to psychiatric examination.[210] These courts reason that a psychiatric interview yields real and not testimonial evidence. Therefore they conclude that the privilege, which obtains only to compelled testimony or communications is inapplicable. This reasoning assumes that the disclosures made in a psychiatric interview are not probative because of their content as assertions but only as a physical characteristic indistinguishable from a fingerprint or blood sample. As a ground for rejection of the privilege this analogy is shoddy.[211] Even if the person examined does not admit the commission of a relevant act, his statements describing his perception of the world around him will be considered by the psychiatrist in evaluating his mental condition. Unlike the use of speech in a lineup situation where the speech pattern may help to identify the declarant, the patient's speech here is important primarily because of its content. The speech pattern is itself important to the psychiatrist in civil commitment as an aspect of the content of the speech. Thus the real and testimonial evidence distinction is inadequate to support a rejection of the privilege in this context. But another far more substantial hurdle exists in terms of the purposes of the fifth amendment in criminal proceedings and the relevance of those purposes in civil commitment proceedings. Among the many purposes sought to be served

207 99 S. Ct. at 1806.

208 TEX. PEN. CODE ANN. tit. 3, § 12.21 and tit. 5, § 22.07 (Vernon 1974). Although the Court's cryptic referent to "assault by threat" does not reveal the specific act, it is quite likely that the assault constituted a class "C" misdemeanor which carries only a fine and no possible imprisonment. TEX. PEN. CODE ANN. tit. 3, § 12.23 (Vernon 1974).

209 Schmerber v. California, 384 U.S. 757, 764 (1966). In *Schmerber* the Court explained that a blood sample belonged to a class of evidence categorized as real evidence. Because the court articulated a distinction in application of the privilege against self-incrimination to testimonial but not real evidence, the privilege did not bar a compelled blood withdrawal and subsequent analysis. *See also* Gilbert v. California, 388 U.S. 263 (1967); United States v. Wade, 388 U.S. 218 (1967).

210 *E.g.*, United States v. Weiser, 428 F.2d 932, 936 (2d Cir. 1969); United States v. Baird, 414 F.2d 700, 708-09 (2d Cir. 1969); State v. Whitlow, 45 N.J. 3, 9, 210 A.2d 763, 771 (1965).

211 "[T]he focus of the mental examination is not to invoke evidence of behavior, per se. Rather the objective is to learn about the individual's mental condition." *Legal Issues in State Mental Health Care: Proposals for Change, supra* note 1, at 101. *See also* Thornton v. Corcoran, 407 F.2d 695, 700 (D.C. Cir. 1969); Aronson, *supra* note 173, at 67-69; Note, Miranda *on the Couch: An Approach to the Problems of Self-Incrimination, Right to Counsel, and* Miranda *Warnings in Pre-Trial, Psychiatric Examination of Criminal Defendants,* 11 COLUM. J.L. & SOC. PROB. 403, 429-31 (1975).

by the privilege against self-incrimination,[212] one of the most significant is the relationship it seeks to describe between the state and individual:

> We have recently noted that the privilege against self-incrimination—the essential mainstay of our adversary system—is founded on a complex of values, *Murphy v. Waterfront Comm'n,* 378 U.S. 52, 55-57, n. 5 (1964); *Tehan v. Shott,* 382 U.S. 406, 414-415, n. 12 (1966). All these policies point to one overriding thought: the constitutional foundation underlying the privilege is the respect a government—state or federal—must accord to the dignity and integrity of its citizens. To maintain a "fair state-individual balance," to require the government "to shoulder the entire load," 8 Wigmore, Evidence 317 (McNaughton rev. 1961), to respect the inviolability of the human personality, our accusatory system of criminal justice demands that the government seeking to punish an individual produce the evidence against him by its own independent labors, rather than by the cruel, simple expedient of compelling it from his own mouth. *Chambers v. Florida,* 309 U.S. 227, 235-238 (1940). In sum, the privilege is fulfilled only when the person is guaranteed the right "to remain silent unless he chooses to speak in the unfettered exercise of his own will." *Malloy v. Hogan,* 378 U.S. 1, 8 (1964).[213]

Implicit in the notion that the government "shoulder the entire load" is the assumption that in the class of cases to which the privilege applies, it is possible for the government to do this and still prevail in appropriate cases.[214] Evidence other than information from the accused must be sufficient to support a verdict for the government. This is true, at least theoretically,[215] in criminal cases.

In civil commitment proceedings it is necessary for the government to show that the proposed patient is mentally ill and in need of treatment or mentally ill and dangerous to himself or others.[216] What will permit the government to demonstrate independently the mental illness of the proposed patient? Although descriptions of the patient's behavior and uncompelled statements will shed light on his mental process, the exclusive use of this kind of evidence will ordinarily result in an ambiguous suggestion of the patient's thought process.[217] If the evidence is rigorously scrutinized, evidence of the patient's behavior alone may not suffice to permit a finding of mental illness. Perhaps patient cooperation is required for a reliable diagnosis.[218]

In light of this critical distinction between criminal and civil commitment

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212 8 J. WIGMORE, *supra* note 72, § 2251, at 310-18. Wigmore lists twelve different policies which have been utilized to justify the privilege against self-incrimination. He contends that the number of justifications advanced is a function of a flexible privilege which is not the same in different contexts. *Id.* at 296.

213 Miranda v. Arizona, 384 U.S. at 460.

214 Although one may theorize the perfect crime for which a successful prosecution cannot be maintained because of the absence of any evidentiary loose ends, we assume that this degree of perfection will not be attained with any substantial frequency. Where this occurs, the failure of conviction without compelled testimony is an unavoidable cost of maintaining the desired balance.

215 384 U.S. 436.

216 *Developments in the Law,* note 1 *supra,* at 1201-07.

217 Our civil commitment laws do not seek to commit people who are dangerous; rather, they seek to commit the mentally ill. The failure to permit psychiatric examinations of the patient may result in an expansion of the concept of mental illness in civil commitment to include all seemingly irrational behavior. *See* Powell v. State, 579 F.2d 324, 332 (5th Cir. 1978).

218 Gomes v. Gaughan, 471 F.2d 794 (1st Cir. 1973); French v. Blackburn, 428 F. Supp. 1351, 1358 (M.D.N.C. 1977); State v. O'Neill, 274 Or. 59, 545 P.2d 97 (1976); Hawks v. Lazaro, 202 S.E.2d 109, 126 (W. Va. 1974); Krash, *The Durham Rule and Judicial Administration of the Insanity Defense in the District of Columbia,* 70 YALE L.J. 905, 918 (1961); Orland, *supra* note 131, at 686; *Developments in the Law, supra* note 1, at 1308-12.

proceedings the argument for application of the fifth amendment is seriously undermined. If a rigorous standard of persuasion is to be applied, can any case lacking psychiatric testimony based upon a personal interview of the patient survive a motion for a directed verdict?[219]

In the absence of a limitation on compelled testimony derived directly from the fifth amendment a pragmatic analysis undertaken under the due process clause of the fourteenth amendment may yield a similar limitation.[220] The analysis which proceeds under the due process clause entails a balancing of the interests protected by the privilege against the costs of its application. The costs of applying the privilege include the strong possibility of an inability to commit where the privilege is not waived, thereby leading to a virtual destruction of the commitment process.[221] Thus, only if the interests protected by the privilege[222] in this context outweigh the desirability of permitting civil commitment can invocation of the privilege be permitted.

Certain compromise solutions have been advocated. The proposal of the Mental Health Law Project is the most innovative. The Mental Health Law Project's Legislative Guide[223] proposes that the privilege against self-incrimination apply in commitment proceedings and that the burden of persuasion[224] to the proposed patient on certain issues if the privilege is invoked. The difficulty with this creative response to the problem is that it still deprives the state of access to evidence which is not available elsewhere and may be necessary if the state is to sustain its burden of persuasion. If the proposed patient satisfies his burden of production on these issues by presenting the testimony of his psychiatrist, the state still lacks access to the probative evidence it will need to succeed. It may cross-examine the patient's witnesses yet it still may not compel a psychiatric examination of the patient himself. Moreover, the constitutionality of imposing the burden of persuasion on the proposed patient as a consequence of exercising a constitutional right raises other constitutional problems.[225]

Other proposed solutions to the problem of compelled patient disclosures

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219 This prophecy of doom of course ignores the fact that in a number of jurisdictions the privilege against self-incrimination now applies to commitment proceedings and these proceedings have not been substantially impeded. Whether the explanation for this is a loose analysis of waiver, insubstantial scrutiny of evidence through a very low standard of persuasion, or a failure of the author's argument requires field study. It is fair to suggest at this juncture, however, that the initial impact of tightening in one area has been a loosening, albeit unauthorized, in another area. *See* Zander, *Civil Commitment in Wisconsin, The Impact of* Lessard v. Schmidt, 1976 WIS. L. REV. 503, 517, suggesting that patient invocation of the fifth amendment privilege against self-incrimination in Wisconsin following *Lessard* has led to judicial fudging of the standard of persuasion.

220 *Developments in the Law, supra* note 1, at 1306.

221 *See* note 218 *supra.*

222 8 J. WIGMORE, *supra* note 72, § 2251, at 310-318.

223 *Legal Issues in State Mental Health Care: Proposals for Change, supra* note 1, at 139-40.

224 The notion of shifting evidentiary burdens based upon one party's better access to the evidence is not unique to the Mental Health Law Project's proposal. Professor Cleary suggests that access to proof is one of the most significant factors in allocating evidentiary burdens. Cleary, *supra* note 136, at 12. Ordinarily, however, although one party may enjoy better access, the other party is not absolutely denied such access. The Project's proposal would absolutely deny access to evidence of the patient's condition through a compelled psychiatric interview.

225 Unlike Patterson v. New York, 432 U.S. 197 (1977), where the Court found constitutional the allocation of insanity questions as an affirmative defense to which the accused was assigned the burden of persuasion, the Project's proposal would assign the patient the responsibility of proving an aspect of sanity, one of the core issues in the proceeding, without any evidentiary showing by the state. Moreover, the shifting may be an impermissible punishment for the exercise of a constitutional right. Suzuki v. Alba, 438 F. Supp. 1106, 1112 (D. Hawaii 1977).

would permit defense counsel or psychiatrists to be present at the psychiatric interview.[226] Even if the presence of these third parties is not disruptive in this situation as many have surmised,[227] this approach assumes that the psychiatrist's opinion will be gleaned from one or more isolated interviews with the patient. It is far more likely that numerous planned and unplanned patient contacts with aides, nurses, and medical staff will provide the support for a considered opinion. Although defense counsel or psychiatrist might make the logistical arrangements to be presented at a single examination, it is not likely that either will wish to be the patient's full-time companion in the hospital in order to be present during all of these contacts.

4. Psychiatric Expertise

Psychiatrists testifying in civil commitment proceedings often couch their testimony in the "buzz words" of the relevant statute reciting simply that the prospective patient is mentally ill and dangerous or mentally ill and in need of treatment.[228] The evidentiary predicate[229] to the admission of such testimony is an analysis of whether expert testimony is admissible on these issues, whether the witness qualifies as a expert and whether this form of testimony should be accepted.

The test for expert testimony on a particular question is whether such testimony "will assist the trier of fact to understand the evidence."[230] To make this preliminary determination the judge must decide whether mental illness, its treatment, and the consequences of failure to treat it are matters of such common knowledge that a juror would not be assisted by expert testimony. The response to this question has been that these issues are not a matter of common knowledge and thus expert opinion may be received.[231] The conclusion that the average lay juror is not clairvoyant in matters of mental illness is reasonable. It seems fair to say that most lay individuals lack a thorough understanding of the workings of the human mind. The more troubling question is whether at the present state of the art psychiatrists as a class have the requisite knowledge to be truly classified as expert witnesses in matters of mental illness.

Jay Ziskin, a lawyer and a psychologist, has listed numerous deficiencies

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226 Aronson, *supra* note 173, at 90-92.

227 *E.g.*, United States v. Albright, 338 F.2d 719, 726 (4th Cir. 1968).

228 Wexler & Scoville, *supra* note 15, at 64-65; *Legal Issues in State Mental Health Care: Proposals for Change*, *supra* note 1, at 105.

229 Predicate is used here to describe the analytical hurdles which the admission of such testimony must survive in the face of a timely and specific objection. Other predicates to the admission of such evidence exist in addition to those described in the text. These include such matters as materiality and relevancy, but these matters are not unique to expert testimony and are not discussed herein.

230 FED. R. EVID. 702. The modern trend exemplified by the Federal Rules of Evidence is to permit expert testimony on matters not wholly beyond the ken of the average juror if such testimony would be helpful in understanding the evidence. Lofton v. Agee, 303 F.2d 287 (8th Cir. 1962); Miller v. Pillsbury Co., 33 Ill. 2d 514, 211 N.E.2d 733 (1965). *See also* S. SALTZBURG & R. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL 413 (2d ed. 1977).

231 Ladd, *Expert Testimony*, 5 VAND. L. REV. 414, 419 (1952). A quotation from a recent Fifth Circuit decision in a civil commitment case is illustrative of the judicial response to these questions. "The first criterion, that the person is mentally ill, is strictly a medical judgment that the judge can render only with the assistance of expert medical knowledge. This requirement is to assure that only the truly mentally ill are hospitalized." Powell v. State of Fla., 579 F.2d 324, 332 (5th Cir. 1978).

in contemporary psychiatry which he contends should bar the admission of psychiatric expert testimony.[232] The barrage leveled by Ziskin includes charges that psychiatry is not an established science but rather a hodgepodge of conflicting and unproven theories[233] and that psychiatric evaluations lack reliability and validity.[234] If we accept these claims, does it follow that psychiatric expert testimony should be barred?

The critical function of the expert witness lies not in his recitation of facts observed but rather in "a power to draw inferences from the facts which a jury would not be competent to draw."[235] To draw these inferences the expert utilizes a reasoning process which he has independently discovered or learned through the teachings of others. If this processing of information by the expert is based upon a premise we think to be wholly erroneous (*i.e.*, that the earth is the center of the universe or one plus one is three), then the inferences drawn by the expert will confuse and not enlighten. As a jury protection device, minimum threshold tests for scrutinizing the assumptions which underlie the expert's opinion have evolved:

> Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.[236]

Is psychiatry[237] sufficiently established, has it passed from the experimental to the demonstrable stage?

Perhaps not if one accepts Ziskin's[238] claims. Yet without much furor, courts have routinely accepted psychiatric expert testimony[239] and legislatures have frequently demanded it.[240] Even where the psychiatric profession has itself denied its expertise on a particular issue such as the prediction of

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232 J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 193-204 (1978).

233 *Id.* at 195-96.

234 *Id.* at 198-99. Ziskin compares psychiatric diagnosis which studies have shown to be wrong as often as right; with polygraph examinations which studies have shown to have a higher reliability and validity but have, with rare exception, been denied admission in the face of an objection. *See* J. REID & F. INBAU, TRUTH AND DECEPTION 237 (1966).

235 C. MCCORMICK, *supra* note 97, § 13, at 29.

236 Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923). *See also* United States v. Stifel, 433 F.2d 431, 438 (6th Cir. 1970), *cert. denied,* 401 U.S. 994 (1971).

237 Psychiatrists hold no irrefutable monopoly on expert witness status on such issues. For example, clinical psychologists may also be accorded the same status. Jenkins v. United States, 307 F.2d 637 (D.C. Cir. 1962).

238 Ziskin is not the only commentator who rejects the contention that psychiatrists satisfy the criteria for expert witness status. *See* Ennis & Litwack, *supra* note 124, at 736. In a more subtle tone, Justice Frankfurter observed, "The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment . . . ." Greenwood v. United States, 350 U.S. 366, 37 (1956).

239 *See* note 231 *supra.* The admissibility of expert testimony, particularly under FED. R. EVID. 702, is left largely to the discretion of the trial judge. United States v. Lopez, 543 F.2d 1156, 1158 (5th Cir. 1976), *cert. denied,* 429 U.S. 1111 (1977).

240 S. BRAKEL & R. ROCK, THE MENTALLY DISABLED AND THE LAW 50 (rev. ed. 1971).

dangerousness, this attempt to withdraw its claim to expertise has been denied judicial recognition.[241]

The reversal of this trend seems unlikely in the near future in the absence of virtually unimpeachable proof supporting another theory to explain human behavior. Regardless of the protestations of psychiatrists or their critics, the judicially felt need for some authority to explain aberrant behavior is not likely to lead courts to abandon one school of thought in exchange for a vacuum. And in light of contemporary evidentiary trends away from jury protectiveness, admission of such evidence is perhaps appropriate leaving the jury to evaluate its validity[242] against a Ziskin-type challenge.

Given the desirability or the inevitability of psychiatric expert testimony the next issue is the form which such testimony may take. The form of testimony is one of the essential differences between the testimony of an expert and a nonexpert witness. The nonexpert witness' value in judicial proceedings is the presentation to the judge or jury of the facts which this witness has perceived relevant to the event at issue. Thus the nonexpert witness may be restricted to a factual narration of his perceptions.[243] Although the expert may also testify as to facts perceived, his unique function lies in drawing inferences or reaching opinions from these facts.[244] Thus experts have traditionally been permitted to testify in the form of an opinion or conclusion.[245] Where, however, the psychiatrist's opinion or conclusion in a commitment proceeding merely recites the ultimate criteria for commitment,[246] some fear that the decision-making function is virtually transferred to the psychiatrist.[247]

It is this same feared usurpation of the judge or jury's function which previously led to the exclusion of opinions on ultimate issues in the litigation.[248] The modern trend in evidence law, however, rejects this ultimate issue limitation upon opinion evidence.[249] The basis for the contemporary rejection of this ultimate issue limitation includes the often illusory difference between ultimate and nonultimate facts or issues, frequent inability of the witness to articulate testimony in another form, and the fact-finder's freedom to disregard the expert's testimony.[250]

Rejection of the ultimate issue rule does not, however, lead automatically

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241 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 4.

242 C. McCormick, *supra* note 97, § 203, at 491; Weinstein, *supra* note 12, ¶ 702[01], at 702-09.

243 Courts have understandably found it difficult to distinguish between facts and opinions, and lay witnesses have experienced difficulty in couching their testimony in only the former. Ladd, *supra* note 231, at 414-15. Indeed the difference between fact and opinion is but one of degree. A recognition of this blurred distinction has resulted in a gradual relaxation of the restriction upon lay opinion testimony. One such exception has generally permitted a witness who observed a person to testify as to his sanity. *See, e.g.*, Connecticut Mutual Life Ins. Co. v. Lathrop, 111 U.S. 612, 620 (1884).

Similarly, in civil commitment proceedings the lay witness' use of such terms as sane or insane should not result in the exclusion of the testimony, if it is based upon the firsthand perception of the witness and is otherwise helpful in resolving disputed issues. Fed. R. Evid. 701.

244 C. McCormick, *supra* note 97, § 13, at 29.

245 *Id.*

246 For example, Attorney: "Doctor, would you give us your findings?" Psychiatrist: "He is suffering from a major psychiatric illness and may be dangerous to himself and others." Wexler & Scoville, *supra* note 15, at 41.

247 *Legal Issues in State Mental Health Care: Proposals for Change*, *supra* note 1, at 105.

248 7 J. Wigmore, *supra* note 72, § 1920, at 17 (1940).

249 *E.g.*, Fed. R. Evid. 704, Adv. Comm. Notes, 56 F.R.D. 183, 284 (1973).

250 C. McCormick, *supra* note 97, § 12, at 27-28.

to acceptance of such conclusory testimony.[251] The key to the admission of expert testimony is helpfulness to the judge or jury.[252] Testimony merely reciting the statutory "buzz words" or that the proposed patient is "committable" would lack the requisite helpfulness. Moreover, the use of unexplained psychiatric jargon similarly fails to assist the fact finder.

> A diagnosis of the defendant's condition, while involving conclusions of a kind, is admissible even though a jury is not bound by a diagnosis or a particular diagnostic label on a mental disorder. The jury wants and needs help from the expert, but it does not help a jury of laymen to be told of a diagnosis limited to the esoteric and swiftly changing vocabulary of psychiatry. Every technical description ought to be "translated" in terms of "what I mean by this," followed by a down-to-earth concrete explanation in terms which convey meaning to laymen. A psychiatrist who gives a jury a diagnosis, for example, of "psychoneurotic reaction, obsessive compulsive type" and fails to explain fully what this means, would contribute more to society if he were permitted to stay at his hospital post taking care of patients.[253]

Where the psychiatrist does not himself translate these conclusions into a down-to-earth explanation, the attorney examining or cross-examining the witness should require the witness to translate his testimony into intelligible and meaningful terms.[254]

Although it might normally be expected that counsel functioning within our adversary system would require such a translation, this expectation has not always come to fruition in civil commitment proceedings.[255] Where the system breaks down the trial judge should assume the responsibility for prodding counsel into a more probing examination of the witness[256] or condition the admissibility of such testimony upon a disclosure of the underlying material upon which the opinion is based and the process by which the expert reasons from this material to his conclusion.[257]

In response to these problems the Mental Health Legislature Guide advocates a blanket restriction upon opinions as to certain diagnostic categories.[258] Rather than imposing a blanket restriction on particular diagnostic terminology and thereby risking exclusion of probative evidence, direct or cross-examination of the witness proffering these labels is preferable to exclusion. Where the psychiatrist refuses to provide a meaningful translation of these terms exclusion might then be justified.

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251 *Id.*
252 FED. R. EVID. 702.
253 Campbell v. United States, 307 F.2d 597, 614 (D.C. Cir. 1962) (Burger, J., dissenting). *See also* Washington v. United States, 390 F.2d 444 (D.C. Cir. 1967); Carter v. United States, 252 F.2d 608 (D.C. Cir. 1957).
254 307 F.2d at 615.
255 Wexler & Scoville, *supra* note 15, at 51-60.
256 307 F.2d at 615. *See also* 390 F.2d at 454 n.30.
257 252 F.2d at 617. *See also* FED. R. EVID. 705.
258 *Legal Issues in State Mental Health Care: Proposals for Change, supra* note 1, at 105. The diagnostic categories referred to in the guide are schizophrenic and manic depressive illness. The guide's exclusion of these labels is based upon the guide's conclusion that such labels misrepresent the actual condition of the proposed patient, are the product of demonstrably unreliable diagnosis, and can be substituted with more meaningful descriptive information. *Id.*

5. The Basis of Psychiatric Opinion Testimony

The expert's critical function, noted previously,[259] is drawing inferences from facts. How does the expert learn of these facts to which he applies his reasoning skills? If the expert is a psychiatrist he may have examined the patient himself, he may have been present in the courtroom to hear the testimony of witnesses who observed the patient or have this testimony communicated to him in a hypothetical question, or he may have gained this information from other sources outside the courtroom.[260] These categories of informational predicates to expert opinion are typically referred to as the bases of expert opinion.[261] Where the psychiatrist's opinion is based upon a personal examination of the patient or judicial testimony no absolute barrier to the receipt of his opinion has been erected;[262] however, because the third class of bases raises significant hearsay problems, its evidentiary reception has been mixed.[263] The use of this category of information in civil commitment proceedings is a particularly important question because, more than other physicians, the psychiatrist relies upon a variety of out-of-court sources in formulating his opinions.[264]

a. *Hearsay Problems*

Hearsay "is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."[265] The psychiatrist testifying in court will frequently include as the bases for his opinion statements of the patient's friends or relatives, observations and opinions of other professionals, or the results of specific tests performed upon the patient. Where this information upon which the psychiatrist bases his opinion has not been independently introduced into evidence, a hearsay problem arises.[266] Although it has been maintained that reliance upon these bases is not proscribed by the hearsay rule because the out-of-court statements are not admitted for their truth,[267] that rationale for accepting those bases for the expert's opinion is unsound. When a psychiatrist opines, for example, that the prospective patient's aberrant behavior is not the result of a physiological disfunction, he relies not upon the mere fact that certain tests were performed and results reported but upon the veracity of the test results. When the patient's neighbor describes finding the patient sitting naked in his driveway with a rifle in hand, this statement is considered by the psychiatrist and incorporated into this ultimate opinion if the psychiatrist believes it to be

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259 *See* note 230 *supra.*
260 Rheingold, *supra* note 64, at 489. *See also* Maguire & Hahesy, *Requisite Proof of Basis for Expert Opinion,* 5 VAND. L. REV. 432 (1952).
261 Rheingold, *supra* note 64, at 989.
262 *See* FED. R. EVID. 703, Adv. Comm. Notes, 56 F.R.D. 183, 283 (1973).
263 *See* Maguire & Hahesy, *supra* note 260; Rheingold, *supra* note 64; Comment, *The Admissibility of Expert Medical Testimony Based in Part upon Information Received from Third Persons,* 35 S. CAL. L. REV. 193 (1962).
264 Diamond & Louisell, *supra* note 182, at 1350.
265 FED. R. EVID. 801(c).
266 Diamond & Louisell, *supra* note 182, at 1350.
267 Seidel & Gingrich, *Hearsay Objections to Expert Opinion Testimony and the Proposed Federal Rules of Evidence,* 39 U. MO. K.C.L. REV. 141, 144 (1970).

true and not simply because it was made.[268] The psychiatrist's opinion is a professional translation of these events in which he communicates the meaning of these events to the judge or jury. Accordingly, only if there is evidence of trustworthiness in these out-of-court statements sufficient to override the concerns of the hearsay rule[269] should such statements be the permissible bases of opinion testimony.

The contention that the requisite indicia of trustworthiness is found in such statements has been supported on a variety of grounds: because of the expert witness' skill he will scrutinize and thereby validate the hearsay he uses;[270] where the evidence is derived from technicians or other skilled persons it may on this basis be especially reliable because of its source;[271] the use of such evidence is often a matter of practical necessity;[272] or in any event, the expert's conclusions are sufficiently supported by nonhearsay.[273] Following this reasoning the trend in evidence law, reflected in rule 703 of the Federal Rules of Evidence, is to permit the expert to rely upon the type of facts or data which is "reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject."[274] As applied to medical testimony this result is sound because hearsay pervades all medical testimony.[275] Even if a psychiatrist formulates an opinion based solely upon her observation of the patient, her opinion will incorporate the statements of her medical school teachers, authors of medical texts and articles she has read, and what she has learned in practice.[276] Thus a rigid approach designed to rid medical testimony of any taint of hearsay would effectively rid the courts of medical testimony. The federal rule wisely rejects an all-or-nothing approach to such potentially valuable testimony and instead scrutinizes the reasonableness of utilizing a particular source. No cogent reason exists to vary this approach when applied to civil commitment proceedings.

Although scrutiny under such a commonplace legal standard should not

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268 *See* Note, *Hearsay Bases of Psychiatric Opinion Testimony: A Critique of Federal Rule of Evidence 703,* 51 S. CAL. L. REV. 129, 145-46 (1977); Comment, *The Physician's Testimony—Hearsay Evidence or Expert Opinion: A Question of Professional Competence,* 53 TEX. L. REV. 206, 297 (1975).

269 In order to evaluate a witness' testimony, four critical items must be examined—the witness' original perception of the event, his recollection of that event from the initial perception to the time of narration, his ultimate narration of the event to the fact-finder, and his sincerity. An examination of these critical phases is probably adequate where the narrating witness testifies under oath, in the presence of the fact-finder who may observe his demeanor, and subject to cross-examination. C. MCCORMICK, *supra* note 97, § 245, at 581. *See also* Tribe, *Triangulating Hearsay,* 87 HARV. L. REV. 957 (1974).

270 "As has been repeatedly pointed out, the expert is competent to ascertain the reliability of statements and reports of others and to use only what is relevant and trustworthy. The concept, simply put, is that the doctor validates what he uses." Rheingold, *supra* note 64, at 532. This argument is bolstered by the contention that the physician is called upon in his daily practice to evaluate the reliability of this information in making life and death decisions about his patients. *Id.* at 531.

271 Maguire & Hahesy, *supra* note 260, at 435-36.

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> In psychiatry the past medical and social history of the patient is of prime importance. A psychiatrist hesitates to make a diagnosis without the illumination afforded by what he calls a "longitudinal study of behavior." But he often learns the history of the patient's aberrant behavior only at second or third hand from friends or relatives, perhaps through a psychiatric social worker. Where the law forbids the psychiatrist to rest his diagnosis on such hearsay material, it requires him to base his diagnosis on what from the scientific viewpoint are incomplete data—or run the risk of having his entire testimony thrown out.

M. GUTTMACHER & H. WEIHOFEN, *supra* note 91, at 221.

273 Maguire & Hahesy, *supra* note 260, at 435.

274 FED. R. EVID. 703.

275 Rheingold, *supra* note 64, at 527.

276 *Id.* at 473. *See also* Diamond & Louisell, *supra* note 182, at 1351-53.

be expected to be difficult, preliminary experience with rule 703 is cause for concern. Rather than scrutinizing the reasonableness of expert's use of such evidence, courts have all too frequently interpreted rule 703 as only requiring customary reliance by the experts which violates the express language and purpose of the rule.[277] A group's pattern of behavior should not conclusively establish its reasonableness.[278] Merely because a class of experts utilizes a certain category of information in formulating opinions does not, *ipso facto*, render the use of that information reasonable. Rather this group conduct is simply one of the factors to be considered in determining reasonableness. The court must independently scrutinize the expert's[279] use of such out-of-court sources for the consequence of their use may be denial of effective cross-examination of the declarant. Conceivably, such scrutiny could entail testimony from other psychiatrists and academicians, medical texts or field studies contained in the literature, all screened through the common sense of the judge.[280]

Two distinct questions remain—should we now seek to erect a set of rigid rules defining permissible bases and what should be the remedy for consideration of an impermissible basis? It is premature at this juncture to cast a firm set of rules defining those circumstances in which a psychiatrist might reasonably use extra-judicial sources of information as the basis for an in-court opinion. Instead case-by-case scrutiny is appropriate until predictable patterns emerge and the justifications and challenges to various bases have been examined. However, as an illustration of the approach which might be followed on particular issues consider the following. If it appears that psychiatrists base their prediction of the patient's future dangerousness upon incidents of patient violence observed by another staff member and recorded in the patient's chart, the following question might be raised—is it *reasonable* for a psychiatrist to base a prediction of dangerousness upon an event observed by another staff member when the psychiatrist has not consulted other informational sources, including the patient, concerning the alleged incident? In favor of the reasonableness of exclusively using such a report it might be argued that hospital staff members are professionals trained to report events objectively and any questions of their objectivity go to the weight and not the use of the report as a basis for opinion. In addition, the time expended by the staff's judicial testimony or oral discussion will add costs not justified by the enhanced reliability of the expert's opinion. Conversely, it may be maintained that anyone's perceptions of an event such as a fight, are extremely subjective and without independent verification by the psychiatrist, a prediction of dangerousness may be mistakenly based upon an act of self-defense which should not be considered dangerousness cognizable under civil commitment

277 Note, *supra* note 268, at 144.

278 *See* Texas & Pac. Ry. v. Behymer, 189 U. S. 468, 470 (1903); The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932), *cert. denied*, 287 U.S. 662 (1932).

279 Judicial scrutiny can occur only if the expert recites the basis for his opinion. Thus, many states have made such a recital a predicate to receipt of the expert's opinion. Rheingold, *supra* note 64, at 475-76. The trend reflected by rule 705 of the Federal Rules of Evidence is not to condition receipt of the testimony upon "disclosure of the underlying facts or data," leaving the choice of forcing disclosure to the cross-examiner. Whether extension of this rule to commitment is appropriate in light of the documented inadequacies in zealous patient representation is problematic.

280 This determination is a preliminary question concerning the admissibility of evidence which must be decided by the court. FED. R. EVID. 104(a). State v. Rolls, 389 A.2d 824, 829-30 (Me. 1978).

laws.[281] Such a subjective source should be cross-checked or its use, it can be argued, is unreasonable. Before ruling on this question the court might ask counsel to present any studies which exist addressing the accuracy of narration of this class of persons.[282]

When the court rules that reliance upon a particular source of information utilized by the psychiatrist was not reasonable, will it be sufficient to ask the expert to reconsider her opinion in the absence of such data or will rejection of the entire opinion be necessary? The resolution of this question turns upon the court's confidence in the ability of the psychiatrist to engage in the mental gymnastics necessary to excise the impermissible basis from the permissible basis which supports her opinion and upon the psychiatrist in fact doing this. Unlike the suppression of an unlawful confession where the court can independently examine the informational chain leading to the alleged untainted sources of that same information,[283] here the chain leading from bases to opinion is exclusively within the psychiatrist's mind and therefore realistically susceptible to far more limited judicial scrutiny.

b. *Confrontation Problems*

Merely because the extra-judicial bases for expert testimony survive scrutiny on hearsay grounds does not end the necessary inquiry into their permissible use. The Supreme Court has stated in a series of recent opinions that the confrontation clause of the sixth amendment and the hearsay rule are not synonymous.[284] Although the hearsay rule and confrontation clause are based upon similar considerations, evidence proscribed by the confrontation clause may survive scrutiny under the hearsay rule[285] and, conversely, evidence which survives scrutiny under the confrontation clause may be proscribed by the hearsay rule.[286] Therefore the extra-judicial bases of expert testimony in civil commitment proceedings must be subjected to independent scrutiny under the confrontation clause.[287]

Those courts which have not barred the use of extra-judicial bases for expert opinion under the hearsay rule have also found no difficulties raised under the confrontation clause by the use of this evidence in criminal cases.[288] The

281 Shuman, Hegland, & Wexler, *Arizona Mental Health Services Act: An Overview and an Analysis of Proposed Amendments*, 19 Ariz. L. Rev. 313, 330 (1977).

282 *See, e.g.*, studies described in Steward, *Perception, Memory and Hearsay: A Criticism of Present Law and the Proposed Federal Rules of Evidence*, 1970 Utah L. Rev. 1.

283 *See* Wong Sun v. United States, 371 U.S. 471 (1963).

284 California v. Green, 399 U.S. 149 (1970); Barber v. Page, 390 U.S. 719 (1968); Pointer v. Texas, 380 U.S. 400 (1965).

285 390 U.S. 719; 380 U.S. 400.

286 399 U.S. 149.

287 Although the confrontation clause of the sixth amendment is only expressly applicable in criminal prosecutions, numerous courts have found the confrontation requirement necessitated in civil commitment proceedings under this amendment or as an element of due process. Millard v. Harris, 406 F.2d 964, 973 (D.C. Cir. 1968); Suzuki v. Quisenberry, 411 F. Supp. at 1130; Doremus v. Farrell, 407 F. Supp. at 517. *See also In re* Gault, 387 U.S. 1 (1967).

288 *E.g.*, United States v. Partin, 493 F.2d 750, 764 (5th Cir. 1974); People v. Ward, 61 Ill. 2d 559, 566-68, 338 N.E.2d 171, 176-77 (1975). *But see* United States v. Williams, 447 F.2d 1285 (5th Cir. 1971), *cert. denied*, 405 U.S. 954 (1972), where the court of appeals acknowledged, in scrutinizing an expert witness' testimony in a criminal proceeding based upon out-of-court conversations and corporate documents not in evidence concerning the value of property, that separate hearsay and confrontation questions arise. 447 F.2d at 1287. Thereafter, the court's analysis fell flat when it relied upon California v. Green, 399 U.S. 149 (1970), which permitted a prior inconsistent statement exception to the confrontation requirement because the declarant in fact was present and available for cross-examination to sidestep the confrontation problems. In *Green* the out-of-court statements at issue were those of the in-court witnesses. The confrontation problem

apparent explanation for this symmetry is a failure to recognize a distinction between hearsay and confrontation. Other courts have, however, addressed this issue in a related context where hospital records were sought to be introduced directly in criminal proceedings under the business records exception to the hearsay rule. Although the majority of cases addressing this issue have concluded that such records survive confrontation scrutiny if they survive the hearsay rule,[289] the reasoning of these cases is largely inadequate. The vast majority simply equates hearsay exceptions with confrontation exceptions.[290] But the recent Supreme Court decisions in *California v. Green,*[291] *Dutton v. Evans,*[292] *Barber v. Page,*[293] and *Pointer v. Texas*[294] expressly reject the reasoning of these opinions.

One of the few cases which rejects the confrontation challenge to the use of the business records exception in criminal proceedings after detailed analysis is *People v. Kirtdoll.*[295] In that case the Supreme Court of Michigan acknowledged that, although the hospital records sought to be introduced satisfied the state's business record exception to the hearsay rule, the confrontation clause imposed another hurdle for the admissibility of these records.[296] To determine whether the records satisfied constitutional scrutiny under the confrontation clause the court utilized dying declarations, a recognized exception to the confrontation requirement as a reliability benchmark against which to measure business records.[297] Although this approach and the court's conclusion that business records are of equal or greater reliability than dying declarations is a reasonable approach given the United States Supreme Court's lack of guidance on the subject, the Michigan court's analysis falls short in other regards. The decision to admit dying declarations combines assumptions of reliability with the declarant's unavailability—trustworthiness plus necessity.[298] Indeed virtually every exception to the confrontation requirement has turned upon trustworthiness plus necessity.[299] Ordinarily those persons whose declarations

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in *Williams* resulted not from the experts' out-of-court statements but rather from the out-of-court statements of others, not present and testifying, upon which the expert based his opinion.

289 McDaniel v. United States, 343 F.2d 785 (5th Cir.), *cert. denied,* 382 U.S. 826 (1965); State v. Brierly, 109 Ariz. 310, 509 P.2d 203 (1973); People v. Kirtdoll, 391 Mich. 370, 217 N.W.2d 37 (1974); State v. Durham, 418 S.W.2d 23 (Mo. 1967); State v. Finkley, 6 Wash. App. 228, 492 P.2d 222 (1977); State v. Olson, 75 Wis. 2d 575, 250 N.W.2d 12 (1977).

290 With the exception of *People v. Kirtdoll* and *State v. Olson,* the cases set forth in note 289 *supra* fail to distinguish between hearsay and confrontation.

291 399 U.S. 149.

292 400 U.S. 74.

293 390 U.S. 719.

294 380 U.S. 400.

295 391 Mich. 370, 217 N.W.2d 37. *See also* United States v. Leathers, 135 F.2d 507 (2d Cir. 1943); State v. Olson, 75 Wis. 2d 575, 250 N.W.2d 12 (1977).

296 391 Mich. at 375, 217 N.W.2d at 42.

297 *Id.* at 378-80, 217 N.W.2d at 45-47. One of the difficulties in using dying declarations as a benchmark for trustworthiness or reliability under a confrontation analysis is that the admissibility of dying declarations is "rooted more in history than in reason." R. LEMPERT & A. SALTZBURG, A MODERN APPROACH TO EVIDENCE 462 (1977). The psychological assumptions upon which admissibility is permitted are highly conjectural. Thus, the use of this benchmark may result in confrontation exceptions of very questionable reliability.

298 "It is scarcely necessary to say that to the rule that an accused is entitled to be confronted with witnesses against him the admission of dying declarations is an exception which arises from the necessity of the case." Kirby v. United States, 174 U.S. 47, 61 (1899).

299 Mancusi v. Stubbs, 408 U.S. 204 (1972) (witness who testified at former trial beyond territorial powers of United States); Mattox v. United States, 156 U.S. 237 (1895) (deceased witness testified at former trial). *But see* Dutton v. Evans, 400 U.S. 74 (1970) (co-conspirator's declaration); Dowdell v. United States,

are contained in hospital records are available or at least the introduction of these records is not premised upon actual unavailability; rather, it is inconvenience to the declarants or disruption of hospital functions that excuses the presence of such witness in light of the assumed reliability of such records. Whatever considerations of convenience may suffice to create a hearsay exception, the confrontation clause appears to require actual unavailability through death or other situations where the good faith efforts of the proponent could not bring forth the live witness. It is on this basis, a finding that inconvenience will not excuse the requirement of confrontation, that the courts which reject the hearsay confrontation symmetry have grounded their analysis.[300] Thus, it is argued, only where the declarant whose statement is contained in the hospital record is actually unavailable should those records containing these statements be admitted.[301]

Ultimately, in unraveling this issue, one must face the question whether unavailability is absolutely a predicate to confrontation exceptions to be considered as a separate requirement, to reliability or whether the reliability analysis subsumes this question. At present the resolution of this question must focus on *Dutton v. Evans,*[302] which presented the constitutionality of a state rule permitting admission of a co-conspirator's out-of-court declaration and resulted in the sole confrontation exception which did not require a showing of unavailability. The decision presented a sharply divided Court with a plurality opinion, two concurring and one dissenting opinions.[303] However, both the plurality,[304] and the concurring opinion of Blackmun and Burger rely in part upon the harmless effect of the declaration at issue.[305] If the *Dutton* plurality opinion is simply an aberration explainable by notions of harmless error, then unavailability survives as a requirement for confrontation exceptions. Indeed the focus upon unavailability in the Court's subsequent opinion in *Mancusi v. Stubbs*[306] bolsters the argument that the unavailability predicate survives. If,

221 U.S. 325 (1910). In the course of discussing exceptions to the constitutional requirement of confrontation, the *Dowdell* Court noted, "[d]ocumentary evidence to establish collateral facts, admissible under common law, may be admitted in evidence." *Id.* at 330. The collateral facts discussed here appear to be the converse of the "crucial witness" concept. *See* note 307 *infra.*

300 State v. Tims, 9 Ohio St. 2d 136, 224 N.E.2d 348 (1967); Bennett v. State, 448 P.2d 253 (Okla. Cr. Ct. App. 1968).

301 United States *ex rel.* Henson v. Redman, 414 F.Supp. 678, 681 (D. Del. 1976).

302 400 U.S. 74.

303 *Id.*

304 *Id.* at 87.

305 *Id.* at 90.

306 408 U.S. 204. Baker, *The Right to Confrontation, The Hearsay Rules, and Due Process—A Proposal for Determining When Hearsay May Be Used in Criminal Trials,* 6 CONN. L. REV. 529 (1974); Westen, *Confrontation and Compulsory Process: A Unified Theory of Evidence for Criminal Cases,* 91 HARV. L. REV. 567 (1978); Comment, *The Uncertain Relationship Between the Hearsay Rule and the Confrontation Clause,* 52 TEX. L. REV. 1167 (1974); *The Supreme Court 1970 Term—Foreword: Right of Confrontation: Admissibility of Declaration by Co-Conspirator,* 85 HARV. L. REV. 3, 194-96 (1971).

Professor Westen articulates the "rule" as follows:

> Before it may use a witness' out-of-court statement, the court has an obligation to make a "good faith effort" to produce the witness in person and, having produced the witness, to try to elicit his evidence in the form of direct testimony under oath and in the presence of the jury.

Westen, note 306 *supra,* at 579. Westen proceeds to argue that business records should not be barred by the confrontation clause because the defendant ordinarily has no interest in examining these out-of-court declarants. Regardless of the wisdom of this observation generally, Westen acknowledges that its application should be limited where the records contain psychiatric evaluations or reports where the defendant can reasonably be expected to desire an examination of the declarant. *Id.* at 615-19 n.143. Additionally, Westen's assumption that the defendant would ordinarily have no interest in examining certain declarants is

however, unavailability exists not as a distinct threshold requirement but rather as one of the elements in the reliability calculus, hospital records satisfying the business records exception to the hearsay rule may well survive confrontation scrutiny.

But who is a witness for confrontation purposes; all persons who have made relevant notations in the medical records? The Court's decisions suggest that the witnesses who must be called to satisfy the requirements of the confrontation clause are those persons who are "principal" or "crucial" witnesses.[307] Under this approach where the psychiatrist, for example, concludes that a particular instance of past violence by the prospective patient related to the physician by a third person is an essential fact supporting her prediction of dangerousness this declarant is crucial and should be presented as a constitutional condition precedent to receipt of the psychiatrist's opinion. Conversely where, for example, the declarant's notation of her observation in the hospital records that the patient took his prescribed medication is one of many such observations used to support an opinion that the patient had adjusted to hospitalization it would not seem critical and thus presentation of the declarant nonessential under the confrontation clause.

Should it be concluded that confrontation of a particular out-of-court declarant is not constitutionally compelled, an alternative response to this issue should be considered. Through the use of obligatory pre-trial disclosures the patient's attorney could be notified of those out-of-court declarations which the state will seek to introduce at the hearing.[308] This notice would give the patient's attorney the opportunity to examine the statement and determine whether he should himself subpoena the out-of-court declarant or take other steps to respond to this proposed evidence.

B. *Miscellany*

Where extra-judicial sources of information are utilized not merely as the bases for expert opinion but are introduced directly as independent evidence of a material issue, another set of hearsay and confrontation issues arises. This evidence may be offered in various forms, but the two most likely are the testimony of a live witness or a document in which these out-of-court statements are recorded. The testimony of a live witness which contains an out-of-court statement offered for its truth raises traditional hearsay issues which should be addressed under a traditional hearsay analysis. No unique problems

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problematic. Without knowing the issues involved in a particular lawsuit, the probative value of the records on those issues, or the nature of the declaration, it is impossible to generalize that the defendant would have no interest in examining the declarant at trial.

307 Graham, *The Right of Confrontation and the Hearsay Rule: Sir Walter Raleigh Loses Another One,* 8 CRIM. L. BULL. 99, 129 (1972). *See also* United States v. Puco, 476 F.2d 1099, 1106-07 (2d Cir. 1973), *cert. denied,* 414 U.S. 844 (1974).

308 *See* FED. R. EVID. 803(24) and 804(5). These rules grant the trial court discretion to admit reliable hearsay not excepted by the enumerated class exceptions set forth in those rules. As a condition precedent to the admission of these statements, the proponent must, *inter alia,* give the adverse party advance notice of his intention and the particulars of the statement. *See also* Westen, *supra* note 306, at 617.

are present in the commitment setting which justify disparate treatment of these hearsay questions.[309]

The document which is likely to be offered into evidence is the patient's hospital or medical records. Contained within these records may be numerous categories of data, including the recollection of a staff members' interview with the patient or his friends and relatives, various staff members' observations of the patient on the ward and resulting opinions, psychiatric observation and opinion, and medical or psychological test results. To the extent that all or a portion of these sections of the patient's records are sought to be introduced at the hearing they must be analyzed under all the same rules which apply to in-court witnesses, including the hearsay rule.

Of the numerous exceptions to the hearsay rule which have evolved, the two which are most relevant to a patient's medical records in a public psychiatric hospital are the business records[310] and public records exceptions.[311] Although hospital records have often been recognized as falling within the business records exception,[312] this recognition does not result in blanket admission of relevant records. The applicability of an exception to the hearsay rule merely results in nonexclusion of such evidence on hearsay grounds. The out-of-court declarant must still satisfy the requirements imposed upon in-court witnesses. The testimony must, for example, satisfy the firsthand knowledge and opinion rules. And, to the extent that these records contain privileged communications, these communications do not lose their privileged status merely by being recorded in hospital records.[313]

Courts have also subjected the records to scrutiny for trustworthiness.[314] Under this approach courts have distinguished between recordation of routine facts and more complicated diagnoses.[315] Where the facts observed and recorded in the hospital involve an essentially objective matter, such as the patient's date of admission or administration of medication, the regularity of recording imports a sufficient degree of trustworthiness to except application of the hearsay rule.[316] However, where the matter recorded largely involves conjecture and opinion, courts have found the requisite degree of trustworthiness present in such opinions insufficient to overcome any need for cross-

309 Lessard v. Schmidt, 349 F. Supp. at 1103. The hearsay exceptions likely to arise with a live witness' narration of an out-of-court statement in the commitment process include FED. R. EVID. 803(1) (present sense impression, *e.g.*, "Patient A is hitting patient B"); 803(2) (excited utterance, *e.g.*, "Patient A just hit me"); 803(3) (then existing mental, emotional, or physical condition, *e.g.*, "I, A, intend to hit B"); and 803(4) (statements for purposes of medical diagnosis or treatment, *e.g.*, "Please help me, I cannot stop myself from hitting B"). The use of these exceptions will not be required where the declaration is not thought to be hearsay because it is, for example, an admission made by the patient a party to the action and offered against him, FED. R. EVID. 801(d)(2), or because it is not offered to prove the truth of the matter asserted, FED. R. EVID. 801(c), *e.g.*, "I am Napoleon."

310 FED. R. EVID. 803(6). *See also* WEINSTEIN, *supra* note 12, ¶ 703[2], at 703-12.

311 FED. R. EVID. 803(8).

312 McCormick, *The Use of Hospital Records as Evidence*, 26 TUL. L. REV. 371, 372 (1952). One aspect of this exception which has occasionally troubled courts in applying this exception to hospitals, schools, and churches is the status of such entities as a business. To avoid rejection of such evidence based upon profit motivation as opposed to reliability, rule 803(6) of the Federal Rules of Evidence defines business to include "business institution, association, profession occupation, and calling of every kind, whether or not conducted for profit."

313 McCormick, *supra* note 312, at 373.

314 Palmer v. Hoffman, 318 U.S. 109 (1943).

315 *E.g.*, New York Life Ins. Co. v. Taylor, 147 F.2d 293, 303 (D.C. Cir. 1944).

316 *Id.* at 300.

examination.[317] One particular category of opinions subject to this rule has been psychiatric opinions[318] which are thought to be too conjectural to dispense with cross-examination.[319]

The business records exception contained in rule 803(6) of the Federal Rules of Evidence does not classify particular sources of information such as psychiatric opinion as being without the exception, rather it focuses upon the trustworthiness of the records preparation. Specifically the rule presumes that a recording made near the time of the event based upon personal knowledge and regularly made and kept in that business activity is trustworthy. This presumption may, however, be rebutted by a showing that "the source of information or the method or circumstances of preparation indicate a lack of trustworthiness."[320] This criterion of rule 803(6) may yield the same result as the traditional exclusion of psychiatric opinions from the business records exception. Thus application of the rule to a type of diagnosis which lacked demonstrated reliability[321] and whose use may result in a deprivation of liberty will compel testimony of the live witness instead of the recorded diagnosis.

In addition the business records exception demands that "[e]ach participant in the chain producing the record—from the initial observer-reporter to the final entrant—must be acting in the course of this regularly concluded business."[322] When a nurse routinely notes the medication administered to a particular patient, as she is required by the hospital to do on each day, no problem with this chain exists.

But where, for example, a staff member interviewing the patient's spouse makes a note in the chart of the patient's past behavior related to this hospital staff member by the patient's spouse, this recording would not satisfy the exception because the spouse was not acting in the regular course of business. Thus, unless some other exception to the hearsay rule obtained to this portion of the chain the entire statement would be barred by the hearsay rule.[323]

If the institution whose records are sought to be introduced is a public agency, admission of the records may be sought under the public records and reports exception to the hearsay rule[324] as the result of an agency investigation or matter observed pursuant to a legal duty. However, the decision of the

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317 *Id.* at 304.

318 *Id. See also* United States v. Bohle, 445 F.2d 54, 64-65 (7th Cir. 1971); Birdsell v. United States, 346 F.2d 775, 779 (5th Cir. 1965); Otney v. United States, 340 F.2d 696, 699-700 (10th Cir. 1965). ***But see*** Thomas v. Hogan, 308 F.2d 355, 361 (7th Cir. 1962); Lyles v. United States, 254 F.2d 725, 738-39 (D.C. Cir. 1957), *cert. denied,* 356 U.S. 961 (1958).

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> It is of no reflection upon the profession of psychiatry to say that it necessarily deals in a field of conjecture. Even in the diagnosis of actual insanity, cases are rare in which trained psychiatrists do not come to opposite conclusions. The opinions here relate to a neurosis, a condition short of insanity on which there are countless theories and infinite possibilities. It is difficult to conceive of records in which the right of cross-examination is more important than the conjectures of a psychiatrist on a psycho-neurotic condition.

147 F.2d at 304-05 (footnote omitted).

320 FED. R. EVID. 803(6).

321 *See* text accompanying notes 228-58 *supra* for a discussion of the alleged lack of reliability in psychiatric diagnosis.

322 WEINSTEIN, *supra* note 12, ¶ 803(6)[02], at 803-152.

323 FED. R. EVID. 805.

324 FED. R. EVID. 803(8). Note that showing "a lack of trustworthiness" in the sources of information will result in a rejection of the record. Thus, the presumed trustworthiness of public records may be rebutted here, as well as in the business records exception.

United States Court of Appeals in *United States v. Oates*[325] casts doubt upon the application of that exception in this situation. The public records exception to the hearsay rule is inapplicable in criminal cases where the records contain the observations of law enforcement personnel which are sought to be used against the defendant.[326] In *Oates* the court concluded that a government chemist who tested a substance alleged to be an illegal narcotic was "law enforcement personnel" so that his report was excluded from the exception.[327] If commitment proceedings are considered criminal,[328] this same provision might preclude its application to commitment proceedings by reasoning that the staff of a public institution which involuntarily confines persons pursuant to a legislative authorization are law enforcement personnel. These persons are "employee[s] of a governmental agency which has law enforcement responsibilities."[329]

Moreover, *Oates* concluded that this same bar on law enforcement reports should apply to the business records exception.[330] If this interpretation is accepted in jurisdictions which have adopted a version of the Federal or Uniform Rules of Evidence, then hospital records of the committing or examining hospital may not be excepted from the hearsay bar by the business or public records exception.

If these records survive scrutiny under the hearsay rule, the confrontation clause questions which arise here may be answered by the analysis advanced in the discussion of confrontation problems involved in extra-judicial bases for expert testimony. In each case a separate analysis of the hearsay and confrontation questions must occur. The declarant's availability, reliability, and crucial role in the proceeding must be evaluated as a constitutional condition of admission under the confrontation clause.

IV. Conclusion

Any discussion of the necessity of a physician or psychotherapist patient privilege rests ultimately upon hunches which have not been validated by hard data. Does the presence of a privilege for particular communications encourage therapeutic relationships which would not occur in the absence of a privilege? We simply do not know. If, however, there is any therapeutic relationship where a privilege might be necessary, our best-reasoned hunches suggest that the psychotherapist-patient relationship is such a relationship. The societal stigma attached to mental illness and the personal or sensitive nature of the problems brought to the psychotherapist suggest the need for private communications between the patient and the psychotherapist. The cloak of privacy occasioned by the creation of a privilege recognizes that we should encourage efficacious treatment because of the net benefit to society when its members are healthy in mind and body.

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325 560 F.2d 45 (2nd Cir. 1977).
326 FED. R. EVID. 803(8).
327 560 F.2d at 66-67.
328 *See* text accompanying notes 228-58 *supra*.
329 560 F.2d at 68. Private institutions carrying out this same legislative charge should be similarly treated for purposes of this hearsay exception.
330 *Id.* at 68-72.

Psychotherapeutic treatment is most likely to be effective if it is voluntary. Thus a social policy favoring treatment should favor voluntary treatment because of its efficacy and its respect for personal autonomy. One class of persons who might benefit from voluntary treatment are those persons who now or at some time in the near future may satisfy criteria for civil commitment. We should encourage this class of persons to seek voluntary treatment rather than subjecting them to involuntary treatment. Thus, if there is any justification for a psychotherapist-patient privilege, it should not be excepted in civil commitment proceedings lest we risk discouraging people from seeking treatment for fear of subsequent disclosure and commitment.

Moreover, this exception to the privilege seems to be a vestige of the medical model of commitment. In this model the physicians decided whether commitment should occur. Psychiatric freedom to testify without regard to patient invocation of privilege is essential to this approach. The rejection of this model should include rejection of its oddments which lacks present utility. The harm to society when its members are unhealthy and the greater efficacy of voluntary rather than involuntary treatment also supports a constitutional right to privacy to protect psychotherapeutic communications from compelled disclosure in civil commitment proceedings. The privilege and privacy arguments break down, however, when the relation is not intended to be therapeutic or is not voluntary. Confidentiality is not anticipated and efficacious treatment not likely. Thus, in the absence of institutional restructuring in this context, informational demands for accurate judicial decision-making prevail over any privilege or privacy arguments.

The other potential for limitation on disclosure of patient communications is the privilege against self-incrimination. The crucial question here is whether application of the privilege against self-incrimination when combined with a rigorous standard of persuasion will undermine civil commitment. In the absence of hard data, any conclusions are speculative. Civil commitment requires proof of the proposed patient's mental illness. Direct evidence of mental illness is unavailable. No witness will state that he observed the mental illness as a distinct entity. Rather, witnesses are likely to state that they observed verbal or nonverbal acts which the witness or fact finder may infer are consistent or inconsistent with mental illness. Without the patient's explanation of these acts and other standardized tests of the patient's thought processes, a danger of ambiguity exists. Such ambiguous evidence when measured against a rigorous standard of persuasion may not permit commitment.

Therefore, before other jurisdictions add the privilege against self-incrimination to their list of patient protections in civil commitment proceedings a serious review of judicial decision-making in those jurisdictions which apply the privilege in civil commitment proceedings should occur. If this review concludes that the state's case is made more difficult but not impossible by application of this privilege, the strongest argument against application of the privilege against self-incrimination falls by the wayside. A series of difficult but not insoluble problems remains.

If, however, application of the privilege against self-incrimination and a serious standard of persuasion frustrates the commitment process, a weaker

result is required. If civil commitment is constitutionally permissible, a decision to retain a civil commitment process leaves the standard of persuasion and the privilege against self-incrimination for review. If the Supreme Court concludes that a clear and convincing evidence or beyond a reasonable doubt standard of persuasion is constitutionally compelled in civil commitment proceedings, use of the privilege against self-incrimination in civil commitment proceedings will be ripe for attack.

The evidence in civil commitment proceedings ordinarily includes physician, psychiatrist, or psychologist testimony. Fear that these witnesses will control or confuse the fact finder has led to proposals for limiting or excluding their testimony on certain issues or in certain terms. The danger in setting up such obstacle courses for these witnesses is that a witness' testimony which is otherwise helpful may be rejected for failure to step here or touch that base. Rather than less testimony we should encourage more testimony. It is of little matter if the witness uses a term of art from his discipline so long as this term is explained during his testimony and an opportunity to test the term's precision exists through cross-examination or the introduction of independent evidence. Similarly, it is of little matter if the witness uses the statutory criteria for commitment in his testimony so long as the witness explains why he concludes that these criteria are or are not met in this case.

To the argument that this class of witnesses really knows little about mental illness the same response is appropriate—more testimony, not less. Do not exclude psychiatric testimony but permit a full cross-examination of the witness and the admission of independent evidence which bears upon the expertise of the witness. The fact finder should decide whether to accept the opinions of the purported experts.

The decision to let the fact finder sort out competing or conflicting theories of mental illness assumes not only that the fact finder could understand these various theories but that the other side is provided a realistic opportunity to present this conflicting evidence. Increased jury sophistication supports submission of conflicting theories to them for resolution. Additionally, most civil commitment proceedings throughout the country are probably tried to judges and not juries and thus the jury protection argument is inapplicable. However, even if the fact finder could understand this evidence it does not follow that the evidence will be presented.

Liberalization of the rules of evidence has been premised, in part, upon the liberalization of discovery rules which permit an opponent the opportunity to rebut or put in perspective particular evidence. Because of the short time between the initiation of civil commitment proceedings and the civil commitment hearing, full-blown discovery with depositions, interrogatories, requests for admissions and related devices does not seem feasible. A topic for future study and debate is the development of a modified discovery system for commitment proceedings or the development of notice requirements to serve as a substitute for discovery. Such a notice might, for example, describe the specific acts upon which commitment will be sought, the names of the in- and out-of-court declarants through which the state will seek to prove its case, and the thrust of these declarations. In the absence of these pre-hearing disclosures, the

admission of crucial evidence raising hearsay/confrontation problems must be carefully considered.

Two limitations on the possible presentation of challenges to the witness' expertise exist: counsel may not seek out such evidence and financial barriers may prevent presentation of such evidence. The decision to permit introduction of psychiatric testimony given the acknowledged doubts of its validity necessarily entails a realistic opportunity for the opposing party to challenge this testimony. Therefore, admission of psychiatric testimony concomitantly triggers a judicial commitment to eradicate the passive representation of patients and financial barriers to presentation of conflicting theories of mental illness.

The justification which had been advanced in favor of civil commitment's status as a stepchild of the legal system was that the best interests of the patient required that certain trappings of standard judicial proceedings be excised from civil commitment proceedings. We now recognize that the carving of a separate niche for civil commitment proceedings was wrong and that the judicial system must carefully scrutinize any significant governmental restrictions upon the liberty of a human being—whether intended to kill or cure. Having thus recognized civil commitment's place in the mainstream of judicial proceedings, it would be unwise to begin carving another separate niche for civil commitment by excepting the application of evidentiary rules applicable in other judicial proceedings. Rather those rules of evidence which do come into play in commitment proceedings should be rigorously applied. Normally the adversary system supplies the requisite rigor. Where those forces which normally prompt counsel to enter adversarial confrontation, the trial judge should exercise a more active role in prodding counsel into the role of a competent and zealous advocate; when necessary the judge should examine witnesses himself, or as a last resort, report incompetent or less-than-zealous representation to the bar association disciplinary committee. Short of this drastic alternative, mental health advocacy training sessions should be encouraged by the bench and bar. Where local mental health advocacy programs do not exist to provide a battery of competent mental health lawyers, the judiciary should screen the appointed attorneys to insure that only those with knowledge of mental health law and the substantive disciplines with which it interfaces are appointed to represent patients in commitment proceedings. Finally, counsel should be reimbursed for his services in a manner which encourages rather than discourages full preparation of a case.

Judicial systems of evidence are the product of hundreds of years of experience in dispute resolution. By comparison, rigorous judicial scrutiny of civil commitment is in its infancy. Before rejecting any of these rules of evidence in civil commitment proceedings it would be prudent to give them a fair chance by utilizing them in the adversary context for which they were designed.