

Preserving Confidentiality or Obstructing Justice? Historical Perspectives on a Medical Privilege in Court

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Abstract

An important problem for medical confidentiality in the nineteenth and early twentieth centuries was the question of whether doctors could be required to give evidence in court about their patients' condition. On the one hand, knowledge that personal information might be divulged in open court might prevent patients from consulting a doctor on sensitive illnesses, to the detriment of their health as well as of public health. On the other hand, valuable evidence might be lost through exclusion of medical testimony, perhaps even leading to errors of justice. This paper compares the different approaches that have been taken to this problem in the United Kingdom, the USA and Germany, and highlights key arguments, cases, and regulations that have shaped the issue of a medical privilege in court. It shows that the origins of the different routes taken – from rejection of a medical privilege to its inclusion in codes of civil and criminal procedure – lay in the eighteenth and early nineteenth centuries. Moreover, it suggests that the treatment of confidentiality in court reflected the power relations between the legal and medical professions.

Introduction

One of the main problems for medical confidentiality in the nineteenth and early twentieth centuries was the question of whether doctors could be required to give evidence in court about their patients' condition. The ethical duty of medical secrecy, expressed in the Hippocratic Oath,¹ was widely regarded as constitutive of the physician-patient relationship. It would encourage patients to reveal details that would help the doctor in arriving at the right diagnosis and in choosing the appropriate treatment. Such benefits of confiden-

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¹ 'What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.' (Translation by Ludwig Edelstein). For interpretations of this section of the Oath, see Steven H. Miles, *The Hippocratic Oath and the Ethics of Medicine* (Oxford: Oxford University Press 2004), 149-157.

tiality were seen in some jurisdictions as a reason to exempt doctors from testifying to details of their patients in court. Knowledge that personal information might be divulged in open court might prevent patients from consulting a doctor on sensitive cases of illness, to the detriment of their health as well as of public health. On the other hand, valuable evidence might be lost through exclusion of medical testimony, perhaps even leading to judicial errors.

This conflict, between the court's mission to establish the truth and the desire to protect patients' beneficial, fiduciary relationship with their doctor was at the heart of many debates on medical confidentiality. Was a medical privilege in court, that is, in this context, a right to refuse to give evidence, justifiable in the same way as the recognized legal privilege which protected communications between lawyer and client? Was the relationship between doctor and patient comparable with that between priests and penitents? Should medical secrecy be treated with the same respect as the seal of confession? This article discusses the different approaches tackling the problem of medical confidentiality in court, in Britain, the USA and Germany, and highlights the various arguments adduced by legal and medical commentators.

Legal Preconditions in Britain, the United States, and Germany

The question of a medical privilege first arose in late eighteenth-century England in the trial for bigamy of Elizabeth Chudleigh (1720-1788), Duchess of Kingston.² During this trial, held in 1776 before the House of Peers, the Duchess's surgeon and friend Caesar Hawkins (1711-1786) was asked by Counsel for the Prosecution whether he had known of a previous marriage between her and the naval officer August John Hervey. Hawkins, who had been present at the birth of Chudleigh and Hervey's child, was reluctant to answer the question. Instead he raised the issue of medical confidentiality by repeatedly saying: 'I do not know how far any Thing, that has come before me in a confidential Trust in my Profession, should be disclosed, consistent with my professional Honour.'³ In response, Lord Chief Justice Mansfield (1705-1793) made a statement that would set a precedent for centuries to come:

² For discussion of this case, see Angus H. Ferguson, 'The Lasting Legacy of a Bigamous Duchess: The Benchmark Precedent for Medical Confidentiality', *Social History of Medicine* 19 (2006), 37-53; A.H. Ferguson, *Should A Doctor Tell? The Evolution of Medical Confidentiality in Britain* (Farnham & Burlington, VT: Ashgate 2013), 13-28; Danuta Mendelson, 'The Duchess of Kingston's Case, the Ruling of Lord Mansfield and Duty of Medical Confidentiality in Court', *International Journal of Law and Psychiatry* 35 (2012), 480-489.

³ *The Trial of Elizabeth Duchess Dowager of Kingston for Bigamy, Before the Right Honourable The House of Peers, in Westminster-Hall, in Full Parliament (...) Published by Order of the House of Peers* (London: Charles Bathurst 1776), 119; Thomas Bayly Howell, *A Complete Collection of State Trials*, vol. 20 (London: Longman, Hurst, Rees etc. 1816), 572.

‘if all your Lordships acquiesce, Mr. *Hawkins* will understand, that it is your Judgment and Opinion, that a Surgeon has no Privilege, where it is a material Question, in a Civil or Criminal Cause, to know whether Parties were married, or whether a Child was born, to say, that his Introduction to the Parties was in the Course of his Profession, and in that Way he came to the Knowledge of it. (...) If a Surgeon was voluntarily to reveal these Secrets, to be sure he would be guilty of a Breach of Honour, and of great Indiscretion; but, to give that Information in a Court of Justice, which by the Law of the Land he is bound to do, will never be imputed to him as any Indiscretion whatever.’⁴

None of the Lords objected, and Hawkins subsequently gave evidence. The Duchess of Kingston was eventually found guilty of bigamy.⁵

With Lord Mansfield’s statement, a privilege for medical men to refuse to give evidence about their patients had been rejected in the highest English court. Although occasionally judges lamented the fact that the law of privilege did not extend to medical persons (e.g. Mr Justice Buller in *Wilson v. Rastall* 1792),⁶ Lord Mansfield’s opinion was adopted in most English courts, turning it into a principle of common law.⁷ It became also accepted in Scots law, particularly after Lord Fullerton as one of the judges in a relevant case heard in the Scottish Court of Session (*AB v. CD* 1851) had endorsed it. This case, in which a doctor was sued for breach of medical confidentiality, established on the other hand that secrecy was an integral part of the contract between a medical man and his client.⁸

While in Britain the rejection of a medical privilege in court seems – initially – to have met little opposition, the issue developed differently in the United

4 *The Trial of Elizabeth* (note 3), 120; Howell (note 3), 573.

5 Ferguson, ‘Lasting Legacy’ (note 2), 45-46.

6 Buller cited in Howell (note 3), 575-576: ‘There are cases, to which it is much to be lamented that the law of privilege is not extended: those in which medical persons are obliged to disclose the information, which they acquire by attending in their professional characters. This point was very much considered in the duchess of Kingston’s Case, where sir C. Hawkins, who had attended the duchess as a medical person, made the objection himself, but was over-ruled, and compelled to give evidence against the prisoner.’

7 John Henry Wigmore, *A Treatise on the System of Evidence in Trials at Common Law*, vol. 4 (Boston: Little, Brown, and Company 1905), 3347-3348; W.A. Purrington, ‘An Abused Privilege’, *Columbia Law Review* 6 (1906), 390-392.

8 Ferguson, ‘Lasting Legacy’ (note 2), 47-48; A.H. Ferguson, ‘Exploring the Myth of a Scottish Privilege: A Comparison of the Early Development of the Law on Medical Confidentiality in Scotland and England’, in: Mark Freeman, Eleanor Gordon & Krista Maglen (ed.), *Medicine, Law and Public Policy in Scotland c. 1850-1990. Essays Presented to Anne Crowther* (Dundee: Dundee University Press 2011), 130.

States. In 1828 the state of New York was the first to enact a statute against disclosure of confidential patient information in court:

‘No person duly authorized to practice physic [i.e. medicine] or surgery, shall be allowed to disclose any information which he may have acquired in attending any patient in a professional character, and which information was necessary to enable him to prescribe for such a patient as a physician or to do any act for him as a surgeon.’⁹

The commissioners responsible for the revision of the statutes of New York gave two reasons for this rule. First, they argued that in comparison with the established privilege for communications between attorney and client, which enabled proper preparation for legal proceedings, consultations with a medical adviser were even more deserving of protection against disclosure. Without it, people would refrain from seeking the medical help they needed. Secondly, driven by a sense of professional honour, medical men might be tempted to conceal the truth if they were compelled to give evidence about confidential patient details.¹⁰

By 1889, 20 American states or territories had introduced similar statutes restricting or prohibiting disclosure of patients’ details in court by their physicians or surgeons, unless the patient had consented to it or medical confidentiality had been waived. Often, the rules for a medical privilege were set alongside those that protected communications between attorneys and their clients and confessions made to clergymen or priests.¹¹ The other states continued to follow the English common law rule that there were no restrictions on disclosure of patient details in court.¹²

⁹ N.Y. Rev. Stats. 1st ed. Vol. 2, p. 406, Pt. III, Ch. VII, Tit. III, Art. 8, Sec. 73. Cf. Purrington (note 7), 392. See also Ralph Slovenko, *Psychotherapy and Confidentiality. Testimonial Privileged Communication, Breach of Confidentiality, and Reporting Duties* (Springfield, Ill.: Charles C. Thomas 1998), 22.

¹⁰ Commissioners on Revision of the Statutes of New York, III, 737 (1836). Cited in Wigmore (note 7), 3349-3350.

¹¹ G.W. Field & John B. Uhle, ‘Privileged Communications’, *The American Law Register* 37 (1889), 1-21. By September 1895, the number of states or territories recognizing medical privilege had further increased to 25: Arkansas, California, Colorado, Idaho, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Utah, Washington, Wisconsin, and Wyoming. Tracy C. Becker, ‘Observations concerning the Law of Privileged Communications between Physician and Patient, as Applicable to the Duties of Railway Surgeons’, *Journal of the American Medical Association (JAMA)* 26 (1896), 1065-1066.

¹² At the time no restrictions on the disclosures that a physician could be compelled to make in court existed in Alabama, Arizona, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and West Virginia. Cf. Charles A. Boston, ‘The Law of Evidence concerning Confidential Communications between Physician and Patient’, in: R.A. Witthaus & Tracy C.

The formulation of the relevant statutes varied from state to state, leaving room for different interpretations. For example, the scope of information which was necessary for a doctor to treat a patient, and which was thus protected, was controversial. Moreover, physicians or surgeons consulted for the means of procuring an abortion could in some states be forced to testify about this, regardless of general medical privilege in court. Abortion, then classed as a crime, was not meant to be 'shielded' by medical confidentiality.¹³ In some states (California, Idaho, Minnesota, Montana, North Dakota, Oregon, South Dakota, Utah, and Washington) the statutory medical privilege applied only to civil actions.¹⁴ Finally, if a patient sought damages from her physician for malpractice,¹⁵ or from another party for personal injury, and for this purpose had revealed in court full details of her condition and treatment, she could not then prevent her physician from giving evidence.¹⁶

The New York statute itself was revised several times in the late nineteenth and early twentieth centuries.¹⁷ The revisions provided the option for patients or their attorneys to issue waivers of confidentiality in trials,¹⁸ and permitted doctors to give evidence on the previous mental or physical state of a deceased patient with the consent of a relevant relative, as long as the information did not include confidential communications or facts that might disgrace the memory of the patient.¹⁹ In 1904, nurses were included under the medical

Becker (ed.), *Medical Jurisprudence, Forensic Medicine and Toxicology*, vol. 1 (New York: William Wood & Company 1894), 94.

¹³ Field and Uhle (note 11), 11-12; 'Medical Confidences', *JAMA* 33 (1899), 1431.

¹⁴ Becker (note 11), 1066; Boston (note 12), 96; Samuel I. Jacobs, 'Evidence: Privileged Communications between Physician and Patient in California: Cal. Code Civ. Proc. § 1881 (4)', *California Law Review* 20 (1932), 304.

¹⁵ Medical malpractice suits became frequent in America from the 1840s; see James C. Mohr, 'American Medical Malpractice Litigation in Historical Perspective', *JAMA* 283 (2000), 1731-1737.

¹⁶ 'Privilege Waived by Bringing of Action for Malpractice – Evidence of Defense by Medical Society not Admissible', *JAMA* 58 (1912), 511; 'Construction of Statute Relative to Privileged Communications – What Adjudged Waivers – Application to Several Physicians', *JAMA* 61 (1913), 1837-1838; 'Privileged Communications Under Amended Statute', *JAMA* 64 (1915), 1446; 'Waiver of Privilege by Plaintiffs', *JAMA* 79 (1922), 2250; 'Waiver of Privilege in Personal Injury Case', *JAMA* 80 (1923), 1172; 'When Doctrine of "Res Ipsa Loquitur" Applies', *JAMA* 91 (1928), 1919-1920; Hugh Emmett Culbertson, *Medical Men and the Law: A Modern Treatise on the Legal Rights, Duties and Liabilities of Physicians and Surgeons* (Philadelphia and New York: Lea & Febiger 1913), 299-300; Lloyd Paul Stryker, *Courts and Doctors* (New York: The Macmillan Company 1932), 34-40.

¹⁷ Specifically: in 1891, 1892, 1899, and 1904. See Purrington (note 7), 402-403; 'Privileged Communications', *JAMA* 62 (1914), 1351.

¹⁸ 'Physical Examination and Privilege Waiving', *JAMA* 48 (1907), 903.

¹⁹ Boston (note 12), 98, 107-108; Stryker (note 16), 38-39. In contrast to this, the Supreme Court of Wisconsin took the view that only the patient can waive the privilege of secrecy and that therefore after the patient's death 'the physician's lips are forever sealed under all circumstances'. Cf. 'Wisconsin Doctrine as to Privileged Communications', *JAMA* 47 (1904), 1577. In the same vein, the Supreme Court of Mississippi ruled in a case of contested will that it was error to

privilege in court, and in 1905 an addition was made, compelling disclosure of information when a crime against a child under the age of sixteen was suspected.²⁰

In Germany, yet another approach was taken towards the question of medical secrecy. Prussian regulations forbidding medical personnel from disclosing private details of their patients had existed since the eighteenth century. The Medical Edict of 1725 ruled that ‘medical men must not reveal to anyone the secret faults and ailments which they have discovered’.²¹ A more comprehensive regulation was included in the *Preußisches Allgemeines Landrecht* (Prussian General Law) of 1794, determining that doctors, surgeons and midwives must not reveal ‘ailments and family secrets that come to their knowledge, as long as these are not crimes’.²²

Subsequent legislation was influenced by the French *Code pénal* (1810) which in its article 378 required secrecy of doctors, surgeons, pharmacists, midwives and others who obtained confidential information through their profession, unless disclosure was demanded by law. Punishment for violation of this article could range from one to six months’ imprisonment or fines between 100 and 500 francs.²³ Section 155 of the Prussian Penal Code of 1851 similarly ruled that ‘medical persons and their helpers’ and others were punishable with imprisonment up to three months or a fine up to 500 thaler if they disclosed ‘without authorization’ secrets which had been entrusted to them due to their office, profession or trade.²⁴ Some other German states, for example Hanover (1840), Hessen (1841) and Nassau (1849), punished breaches of confidentiality only if they had been made with malicious intent or in order to gain unlawful advantage.²⁵ After unification of the German states, the new Reich Penal Code of 1871 followed the Prussian model in its section 300. Including the legal as well as the health professions it ruled:

admit the testimony of a physician about the deceased patient’s senile dementia. Cf. ‘Statutes Relative to Privileged Communications and Vital Statistics’, *JAMA* 79 (1922), 325.

²⁰ Purrington (note 7), 403.

²¹ Bjarne Exner, *Das Berufsgeheimnis des Arztes gemäß § 300 des Str. G. B.* (Jur. Diss., Ruprecht-Carls-Universität Heidelberg 1909), 11.

²² *Preußisches Allgemeines Landrecht*, Teil 2, Tit. 20, § 505. Cf. Siegfried Placzek, *Das Berufsgeheimnis des Arztes*, 3rd enlarged and revised edition (Leipzig: Georg Thieme 1909), 2.

²³ *Ibid.*, 49. The French legal requirement of professional secrecy was taken to be ‘absolute’, applying also to evidence in criminal trials. See for example: ‘Professional Secrecy’, *JAMA* 35 (1900), 104. For a discussion of medical confidentiality in France, see Raymond Villey, *Histoire du Secret Médical* (Paris: Seghers 1986).

²⁴ Placzek (note 22), 7.

²⁵ *Ibid.*, 4-5.

‘Lawyers, advocates, notaries, counsels for the defence, physicians, surgeons, midwives, apothecaries, as well as the assistants of these persons are punished with a fine of up to 1500 Mark or imprisonment up to three months, if they reveal without authorization private secrets which have been entrusted to them due to their office, profession or trade.’²⁶

The confidentiality of professionals was thus in Germany a general legal duty. Breaches of professional secrecy were punishable under the rules of the Penal Code, unless disclosure had been authorized by the entrusting patient or client, or if it was required by law. Legal exceptions to the duty of secrecy pertained to knowledge about plans for serious crimes (section 139 of the Penal Code) including treason, counterfeiting, murder, robbery and abduction, as well as a possible bomb attack (section 13 of the Explosives Law of 1884).²⁷ Reporting to the police or the warning of relevant persons was meant to prevent these crimes. Doctors were also obliged to notify the health authorities of specific infectious diseases under the Law for the Combat of Dangerous Diseases of 1900.²⁸ In addition, they had to provide official lists of vaccinated persons under the law on compulsory vaccination against smallpox (1874).²⁹ Finally, doctors had to report births (if they had been present at them) to the registrar, and directors of mental asylums had to notify the authorities of admitted patients.³⁰

Initially, it was unclear whether doctors were entitled to refuse to give evidence in court on the grounds of section 300. However, with the Codes of Criminal Procedure (section 52) and Civil Procedure (section 348) of 1877, which came into effect in 1879, German doctors became entitled to refuse to give testimony regarding private details of their patients – unless the patient concerned had waived medical confidentiality, in which case the doctor had to testify.³¹ Section 300 did not apply to legal cases in which a doctor faced charges of malpractice or was accused of demanding excessive fees. Here, the doctor

²⁶ Cf. Reichs-Strafgesetzbuch (RStGB), § 300. Cf. Placzek (note 22), 2.

²⁷ *Ibid.*, 29.

²⁸ Gesetz, betr. die Bekämpfung gemeingefährlicher Krankheiten, 30 June 1900. Cf. Placzek (note 22), 30.

²⁹ Exner (note 21), 41; Hans Weizmann, *Das Berufsgeheimnis* (§ 300 RStGB.) (Jur. Diss., Universität Breslau 1909), 25.

³⁰ Heinrich Schmidt, *Das ärztliche Berufsgeheimnis* (Jur. Diss., Universität Leipzig; Jena: Gustav Fischer 1907), 19-20.

³¹ J. Liebmann, *Die Pflicht des Arztes zur Bewahrung anvertrauter Geheimnisse* (Frankfurt a. M.: Joseph Baer & Co. 1886), 6-8; Placzek (note 22), 32.

could reveal, without the patient's consent, details of the treatment that were necessary for his defence, or to justify his claims.³²

If one compares these legal preconditions for medical confidentiality in court in Britain, the United States and Germany in the nineteenth century, it appears that Germany, with its legal recognition of patients' interest in secrecy, provided the strongest protections, and Britain, with its precedents of rejecting a medical privilege, the weakest. The USA seem to have taken an intermediate position, particularly if one considers that only about half of the states or territories enacted medical privilege statutes and that in some states these statutes pertained to civil actions only. The role of the doctor on the witness stand remained contested.

American Debates on Confidentiality in Court

As mentioned above, unease about the rejection of a medical privilege in British courts had occasionally been expressed even from within the legal profession. William Mawdesley Best (1809-1869), in his handbook *The Principles of the Law of Evidence*, characterized this practice as 'a rule harsh in itself, of questionable policy, and at variance with the practice in France, and in some of the United States of America'.³³ This opinion contrasted, however, with the views of several American legal experts who criticized the New York statute and its successors. For example, New York barrister Charles A. Boston held that the statutes 'have not proved an unalloyed benefit, and some of their features have brought about conditions which in some cases have embarrassed the administration of justice'.³⁴ Concerning the New York statute he highlighted the fact that it prevented a physician from 'disclosing the condition of his patient who is a lunatic or habitual drunkard' as well as from stating a patient's cause of death, and that it excluded much testimony which might have demonstrated fraud in insurance cases.³⁵ Similar concerns were expressed by barrister William Archer Purrington (1852-1926). He claimed that the introduction of the medical

³² Important for this view was a decision of the District Court of Hamburg on 24 June 1899; see W. Mittermaier, 'Gutachten über § 300 R.St.G.B.', *Zeitschrift für die gesamte Strafrechtswissenschaft* 21 (1902), 229-230. See also Friedrich Ottomar Jummel, *Der § 300 Str.G.B., ein Versuch seiner Auslegung* (Jur. Diss., Universität Leipzig 1903), 54.

³³ William Mawdesley Best, *The Principles of the Law of Evidence with Elementary Rules for Conducting the Examination and Cross-Examination of Witnesses*, first American, from the sixth London edition of John A. Russell, by James Appleton Morgan, vol. 2 (New York: Cockcroft & Company 1878), 987-988. Best's handbook saw twelve editions. In addition to publication in Britain and the USA, it was also published in India and Germany.

³⁴ Boston (note 12), 134.

³⁵ *Ibid.*

privilege in New York and other states had opened the door to fraud. In his experience, in some legal actions brought to recover damages for physical injuries, the medical privilege had been used to suppress the 'best available evidence' if this was in the plaintiff's interest. He therefore called for changing, if not altogether repealing, the privilege statute.³⁶

John Henry Wigmore (1863-1943), Professor of the Law of Evidence at Northwestern University, asked in 1905 four critical general questions about privilege for communications between doctor and patient:

'[1] Does the communication originate in a confidence? [2] Is the inviolability of that confidence vital to the due attainment of the purposes of the relation of physician and patient? [3] Is the relation one that should be fostered? [4] Is the expected injury to the relation, through disclosure, greater than the expected benefit to justice?'³⁷

Wigmore answered only the third question in the affirmative. Regarding the first question, he maintained that only in a few instances, such as venereal disease and abortion, had patients any real interest in keeping their condition secret. Concerning the second question he argued that the possibility of disclosure in court would not deter people from seeking medical help. Polemically he asked: 'Is it noted in medical chronicles that, after the privilege was established in New York, the floodgates of patronage were let open upon the medical profession, and long concealed ailments were then for the first time brought forth to receive the blessings of cure?'³⁸ Finally, he answered the fourth question by claiming that 'injury to justice by the repression of the facts of corporal injury and disease' was 'a hundred fold greater than any injury which might be done by disclosure', particularly in divorce proceedings and in cases of criminal abortion.³⁹

On the other hand, from the side of the medical profession, it was maintained that the 'machinery for the conviction and punishment of crime' operated as well in those states that had medical privilege in court as in those that had not. This point was made by Daniel R. Brower, Professor of Mental Diseases at Rush Medical College, Chicago, and Northwestern University, in an address to the

³⁶ Purrington (note 7), 393-394, 422. See also William A. Purrington, 'Of Certain Legal Relations of Physicians and Surgeons to Their Patients and to One Another', in: Allan McLane Hamilton & Lawrence Godkin (ed.), *A System of Legal Medicine* (1894), 2nd edn, vol. 1 (New York: E. B. Treat & Co. 1900), 626.

³⁷ Wigmore (note 7), 3350. See also Daniel W. Shuman, 'The Origins of the Physician-Patient Privilege and Professional Secret', *Southwestern Law Journal* 39 (1985/86), 663.

³⁸ Wigmore (note 7), 3350.

³⁹ *Ibid.*, 3351.

local Medico-Legal Society in 1896. Brower argued here for the introduction of statutory medical privilege also in the state of Illinois. He claimed that his medical colleagues in the Society would rather go to prison for contempt of court than violate secrecy and expose the character of their patients in a court of law.⁴⁰

However, the opposition to medical privilege by some members of the legal profession made it difficult for physicians to achieve legislation on this matter. In January 1897, physician F.L. Hall of Perry, Illinois, a member of the Legislature, introduced a bill providing for medical secrecy along the lines of the New York statute.⁴¹ By the end of May, his colleague John B. Hamilton, Professor of Surgery at Rush Medical College, had to report that Hall's bill had already failed at the committee stage. With bitter irony, Hamilton described how 'an old lawyer with snowy looks and hands trembling with age wrought himself into a storm of passion in denouncing it', and how the 'awe-struck committee, conscience-smitten for having for a moment dared to look at a bill introduced by a physician' brought the proposal down.⁴² At about the same time, physician James B. Baird campaigned in Georgia for the enactment of a medical privilege statute. Emphasizing the fact that 20 American states had by then such regulations, he claimed that public opinion was 'decidedly in favor of protecting the professional secrets of physicians'.⁴³

Views on what the public thought about the need for protecting medical confidentiality in court were thus contradictory. Baird's assessment of public opinion on this question contrasted with that of Wigmore who held that most people did not worry about this matter. Nevertheless, the intensity of the medico-legal debate on this issue during the 1890s suggests that it may have been fuelled by more general concerns about privacy – at least among the social and intellectual elite.

In December 1890 the now famous article 'The Right to Privacy' by Boston attorneys Samuel Warren (1852-1910) and Louis Brandeis (1856-1941) was published in the *Harvard Law Review*.⁴⁴ Drawing upon English legal cases they ar-

⁴⁰ Daniel R. Brower, 'The Necessity of Granting Privileged Communications to the Medical Profession in the State of Illinois', *JAMA* 27 (1896), 1271-1273.

⁴¹ 'Professional Communications to Physicians Should Be Privileged', *JAMA* 28 (1897), 374.

⁴² John B. Hamilton, '"Medical" Legislation and How to Obtain It', *JAMA* 28 (1897), 1005-1006.

⁴³ James B. Baird, 'The Medical Witness. His Rights and Wrongs in Courts of Justice', *JAMA* 32 (1899), 1149.

⁴⁴ Samuel D. Warren & Louis D. Brandeis, 'The Right to Privacy', *Harvard Law Review* 4 (1890), 193-220.

gued for recognition of an individual's 'right to be let alone'.⁴⁵ It has been said that the immediate occasion for writing on privacy was Warren's annoyance about newspaper reports on his and his wife's glamorous dinner parties, and the main thrust of the article aimed at the practices of the press, including the use of photographs made with the then newly available 'snap cameras'.⁴⁶ Warren and Brandeis described, however, a much more general need for privacy in modern, complex society, and recognized that invasion of an individual's privacy caused 'mental pain and distress, far greater than could be inflicted by mere bodily injury'.⁴⁷ While disclosure of patients' secrets was not directly discussed by them,⁴⁸ their general assessment of people's need for 'solitude and privacy' indicated a contemporary social climate that was conducive to protecting medical secrecy.

How did this American debate compare with the situation in Germany, which, as we have seen, protected professional secrecy through its Penal Code, and in Britain, where a medical privilege in court had been rejected?

Medical Privilege in Germany

In the immediate years after the regulation of professional secrecy through section 300 of the Reich Penal Code, doctors' communications with their patients were still unprotected in court. While lawyers and priests were not required to testify, physicians and surgeons could be forced to give evidence about their patients. In 1875, a decision of the Reich Justice Commission (*Reichsjustizkommission*) planned a right to compel any expert to testify in court, because the expert 'owed his knowledge to the state'. From the perspective of the medical profession this was an unjustified expropriation of intellectual property.⁴⁹ Eventually, from 1879 onwards, section 52 of the Code of Criminal Procedure and section 348 of the Code of Civil Procedure granted doctors the

⁴⁵ Whether the cases cited by Warren and Brandeis were actually precedents showing a right to privacy is questionable, because the decisions in these cases were largely based on property rights. See Walter F. Pratt, *Privacy in Britain* (Lewisburg: Bucknell University Press, and London: Associated University Presses 1979), 19-37.

⁴⁶ *Ibid.*, 19; Raymond Wacks, *Privacy and Media Freedom* (Oxford: Oxford University Press 2013), 53.

⁴⁷ Warren and Brandeis (note 44), 196.

⁴⁸ They briefly referred though to the hypothetical example of Lord Eldon in 1820, that 'if one of the late king's [George III] physicians had kept a diary of what he heard and saw, the court would not, in the king's lifetime, have permitted him to print and publish it'. Warren and Brandeis (note 44), 205.

⁴⁹ Krahmer, 'Der Zeugnisszwang der Aerzte', *Berliner Klinische Wochenschrift* 1875, no. 26-27: 365-366, 378.

‘entitlement’ to refuse to give evidence in court on the grounds of their legal duty of professional secrecy according to section 300 of the Penal Code.⁵⁰

However, this situation raised the question of whether they were obliged to make use of this entitlement, or whether they could choose to testify without their patient’s consent. Some legal authors held that doctors did risk punishment under section 300 if they gave evidence without permission of the patient.⁵¹ Other legal commentators took the view, however, that giving evidence in court, at the request of a judge, could never be an illegal act.⁵² The German Supreme Court (*Reichsgericht*) confirmed in a decision in 1889 that a doctor was free to decide in each particular case, according to his own ‘dutiful judgment and discretion’, whether he wanted to testify concerning his patient or not.⁵³

Yet, in German legal practice, the entitlement of doctors to refuse to give evidence in court was not accepted without challenge. For example, more than 20 years after the Code of Civil Procedure had come into force, a Hamburg physician was involved as a witness in a protracted divorce case that led to two decisions of the German Supreme Court regarding his medical privilege. Steadfastly refusing to give evidence about the alleged venereal disease of the husband on the grounds of medical confidentiality, the doctor was convicted twice by the Higher District Court of Hamburg and ordered to testify. The Supreme Court twice lifted the lower court’s verdict and eventually ruled in January 1903 that the doctor was indeed entitled to refuse to give evidence.⁵⁴

The case illustrated how the implementation of the legal entitlement of German doctors to refuse to give testimony could be controversial, but was eventually assured by the highest court, at least for civil proceedings. In its reasons for the verdict, however, the Supreme Court admitted that there might

⁵⁰ Liebmann (note 31), 6-7; Siegfried Placzek, *Das Berufsgeheimnis des Arztes* (Leipzig: Verlag von Georg Thieme 1893), 6.

⁵¹ Liebmann (note 31), 7; Simonson, ‘Das Berufsgeheimnis der Aerzte und deren Recht der Zeugnisverweigerung’, *Deutsche Juristen-Zeitung* 9 (1904), 1014-1017; Schmidt (note 30), 21-23; Exner (note 21), 42-45.

⁵² Justus Olshausen, *Kommentar zum Strafgesetzbuch für das Deutsche Reich*, 4th revised edition, vol. 2 (Berlin: Verlag von Franz Vahlen 1892), 1142; Fromme, *Die rechtliche Stellung des Arztes und seine Pflicht zur Verschwiegenheit im Beruf* (= Berliner Klinik, no. 165) (Berlin: Fischer 1902), 20-22; Jummel (note 32), 46; Walther Zschok, § 300 *StrGB* (Jur. Diss., Universität Rostock 1903), 46; Léon Seréxhe, *Die Verletzung fremder Geheimnisse* (Jur. Diss., Universität Freiburg i. B. 1906), 84-86; Richard Otto Gans, *Das ärztliche Berufsgeheimnis des § 300 RStrGB* (Jur. Diss., Ruprecht-Karls-Universität Heidelberg 1907), 27-29.

⁵³ *Entscheidungen des Reichsgerichts in Strafsachen* 19 (1889), 364-367 (decision of 8 July 1889).

⁵⁴ Biberfeld, ‘Die Schweigepflicht des Arztes’, *Zeitschrift für Medizinal-Beamte* 15 (1902), 648-650; Dr. H., ‘Ueber Verschwiegenheitspflicht und Zeugnisverweigerungsrecht des Arztes vor Gericht’, *Aerztliches Vereinsblatt* 30 (1903), 248-251; *Entscheidungen des Reichsgericht in Civilsachen* 53 (1903), 315-319 (decision of 19 January 1903).

be cases in which 'higher moral duties' could overrule the duty of confidentiality. As an example the court suggested that a doctor may feel obliged to inform a wife of the venereal disease of her husband in order to protect her against infection as far as possible. Going a step further, the court did not even rule out a moral duty to inform a third party other than the wife.⁵⁵

Despite the relative clarity of the German law on professional secrecy, medical confidentiality was open to legal challenges. How, in comparison, were British doctors treated when they were reluctant to give confidential information in testimony?

The Lack of a Medical Privilege in Britain

Based on the precedent of the Duchess of Kingston case, doctors in Britain were still compelled to give evidence on patient details in the late nineteenth century. A characteristic scenario was the one experienced by the London obstetrician John Braxton Hicks (1823-1897). In a divorce case, he was subpoenaed in order to testify about a consultation of the husband who, a year earlier, had come to see him with worries that he might have infected his then pregnant wife with gonorrhoea. Reluctant to speak, Hicks asked the court whether the husband's communication to him might be privileged, but was told that it was not, and he subsequently gave evidence. Hicks was particularly annoyed that he was put in a situation in which he was forced to provide a testimony that, in effect, was equivalent to a self-incrimination of one of his clients (that is, the husband).⁵⁶

In the contemporary British medico-legal and ethical literature doctors were advised to testify only after a ruling of the judge to this effect,⁵⁷ or even to refuse to give evidence altogether, risking a prison sentence for contempt of court.⁵⁸ As Justice Sir Henry Hawkins (1817-1907) emphasized during a prominent libel case against the obstetrician William Smoult Playfair (1835-1903) in 1896 (*Kitson v. Playfair*), the question of privilege was for the judge to decide, depending on

⁵⁵ *Entscheidungen des Reichsgericht in Civilsachen* 53 (1903), 317-318.

⁵⁶ John Braxton Hicks, 'Notes of Cases in Obstetric Jurisprudence', *The Lancet* 126 (1885), 285.

⁵⁷ John Glaister, *A Text-Book of Medical Jurisprudence and Toxicology* [1st edn 1902] 4th edn (Edinburgh: E. & S. Livingstone 1921), 58; Robert Saundby, *Medical Ethics: A Guide to Professional Conduct*, 2nd edn (London: Charles Griffin & Company 1907), 42. See also 'Foreign Letters: London: Medical Confidences', *JAMA* 89 (1927), 1346.

⁵⁸ Percy Clarke & Charles Meymott Tidy, *Medical Law for Medical Men: Their Legal Relations Shortly and Popularly Explained* (London: Baillière, Tindall, and Cox 1890), 39.

the particular circumstances of a case.⁵⁹ Usually, this meant that the doctor concerned was compelled to testify. Only exceptionally did a judge exempt a doctor from giving evidence, as happened in a matrimonial case before Nottingham magistrates in 1900. Here, the medical evidence might have incriminated the female defendant, and the judge recognized the doctor's concerns that disclosure might make him liable to action by the defendant as well as by his professional body, the General Medical Council.⁶⁰

In fact, in the previous year, the General Medical Council issued a memorandum on professional secrecy of medical practitioners prepared by its legal assessor, Muir Mackenzie.⁶¹ Briefly reviewing the relevant legal cases since the trial of the Duchess of Kingston, Mackenzie concluded that 'a medical man not only may, but must, if necessary, violate professional confidences when answering questions material to an issue in a court of law'.⁶² Moreover, he warned that 'circumstances which according to the custom of the medical profession might be deemed to exonerate him [that is, a medical man] from the imputation of improper violation of secrecy might nevertheless in a court of law be deemed an insufficient justification'.⁶³ The circumstances referred to were criminal communications and protection of a doctor's own wife and children.⁶⁴ British doctors were thus in a position where they could be forced to give evidence in court, but were simultaneously expected to observe strict confidentiality in daily life. A breach of confidentiality could result in charges of slander or libel, and might end with a verdict to pay considerable damages to the patient, as it had happened in the *Playfair* case.⁶⁵

The issue of medical privilege in court became prominent again after World War I when the number of divorce petitions soared. Typically, medical evidence was sought in such cases to prove that a husband had acquired venereal disease outside marriage and subsequently infected the wife. In this way the wife could provide the required proof of adultery and cruelty. With the Public Health

⁵⁹ 'Kitson v. Playfair and Wife', *The Times*, 26 March and 28 March 1896. For a discussion of this case, see Angus McLaren, 'Privileged Communications: Medical Confidentiality in Late Victorian Britain', *Medical History* 37 (1993), 129-147.

⁶⁰ 'The Seal of Professional Secrecy', *The Lancet* 155 (1900), 1292-1293. Breach of confidence was actually a rather rare offence according to the official minutes of the General Medical Council. See Russell G. Smith, *Medical Discipline: The Professional Conduct Jurisdiction of the General Medical Council 1858-1990* (Oxford: Clarendon Press 1994), 103, 106.

⁶¹ Placzek (note 22), 81.

⁶² Muir Mackenzie, 'Memorandum on the Law of the Obligation of Medical Practitioners with Regard to Professional Secrecy', *The Lancet* 153 (1899), 787-788.

⁶³ *Ibid.*, 788. On the libel charge against Playfair by his sister-in-law, Linda Kitson, and his alleged breach of confidence, see McLaren (note 59).

⁶⁴ Mackenzie (note 62), 787.

⁶⁵ McLaren (note 59), 137.

(Venereal Diseases) Regulations of 1916, the English government had established special VD treatment centres which guaranteed confidentiality. This circumstance made the requirement of disclosure in court especially problematic for those doctors who worked at these centres and were subpoenaed to give evidence in divorce trials. Two cases, *Garner v. Garner* (1920) and *Needham v. Needham* (1921), were particularly relevant in this context. In the first case, Mr Justice Henry Alfred McCardie (1869-1933) did not recognize the doctor's protest, stating that there were 'higher considerations' in a court of law than those pertaining to the position of medical men.⁶⁶ In the second case, Mr Justice Horridge did not regard the authority of the 1916 VD Regulations as sufficient to justify medical privilege in court.⁶⁷ In both cases the doctors concerned eventually gave the required evidence.

Attempts by the Ministry of Health to secure medical privilege for civil proceedings failed due to resistance of the judiciary, led by the Lord Chancellor, Viscount Birkenhead (F.E. Smith, 1872-1930).⁶⁸ The influence of the British Medical Association in the matter was hampered by internal differences of opinion.⁶⁹ In 1922, Birkenhead published a strong defence of the traditional view that doctors had no privilege in court and had to support the administration of justice. In his opinion, 'to establish a class who may at their will assist or obstruct the judges in their work would be a retrograde step not justified by any argument which has been brought forward'.⁷⁰

Indeed, in another divorce trial, in Birmingham in 1927, Mr Justice McCardie again demonstrated his uncompromising position: he compelled medical evi-

⁶⁶ 'Law Report, Jan. 13', *The Times*, 14 January 1920, 5; 'Medical Evidence in Divorce. Effect on Treatment Schemes. Value of Secrecy', *The Times*, 15 January 1920; Digby Cotes-Preedy, 'Judges and Medical Privilege', *The Times*, 15 January 1920, 5; 'The Privacy of Venereal Clinics', *The Lancet* 195 (1920), 163; D. Harcourt Kitchin, *Law for the Medical Practitioner* (London: Eyre & Spottiswoode Ltd. 1941), 160-161; Angus H. Ferguson, 'Speaking Out about Staying Silent: An Historical Examination of Medico-legal Debates over the Boundaries of Medical Confidentiality', in: Imogen Goold & Catherine Kelly (ed.), *Lawyers' Medicine: The Legislature, the Courts and Medical Practice, 1760-2000* (Oxford and Portland, Oregon: Hart Publishing 2009), 111-112.

⁶⁷ 'A Doctor's Claim to Privilege. *Needham v. Needham and Bennett*', *The Times*, 10 June 1921, 4; 'Dr. John Elliott', *The Times*, 20 December 1921, 12; Ferguson, 'Speaking Out' (note 66), 114-117.

⁶⁸ For a discussion of the position of the Ministry of Health, see Ferguson, *Should A Doctor Tell?* (note 2), 55-77.

⁶⁹ Ferguson, 'Speaking Out' (note 66), 118-119. For the extensive discussions of the British Medical Association on confidentiality and medical privilege, see Ferguson, *Should A Doctor Tell?* (note 2), 79-109, and Andrew A.G. Morrice, "'Should the doctor tell?' Medical secrecy in early twentieth-century Britain', in: Steve Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain, 1600-2000* (London and New York: Routledge 2002), 60-82.

⁷⁰ Viscount Birkenhead, *Points of View* (London: Hodder and Stoughton Limited 1922), vol. 1, 75. For further details and background to the Lord Chancellor's position in the issue of a medical privilege, see Ferguson, *Should A Doctor Tell?* (note 2), 111-123.

dence on the husband's alleged venereal disease, regardless of the governmental guarantee of confidentiality in VD treatment centres, and against the protest of the medical staff concerned.⁷¹ Speaking subsequently to the Medico-Legal Society, McCardie further defended his position. As the London correspondent of the *Journal of the American Medical Association* reported the judge's speech:

"There were two aspects of the question [of medical secrecy], each of which was vital. There was the physician who said, "Health, health, health, and break down the legal obstacles that prevent the gain of health." Yes, but there was another point of view – and there was not a lawyer whose heart was not stirred – and that was "Truth, truth, truth; open the shutters and let in the full light of truth. Truth lay at the root of criminal justice."⁷²

A private member's bill to allow medical privilege regarding VD cases, introduced into Parliament in 1927 by the dermatologist and MP for the University of London, Ernest Gordon Graham-Little (1867-1950), was unsuccessful, as was his second attempt in 1936/37 with a bill for wider medical privilege. Lacking ministerial support and unclear in its potential consequences, Graham-Little's initiative failed under the pressure of legal criticisms.⁷³ Cases such as that of *Garner v. Garner* had set important new precedents for the lack of a medical privilege in British courts. The case is still cited nowadays on this point.⁷⁴

Conclusions

As this article has shown, the course of policies regarding medical confidentiality in court in Britain, the USA and Germany was determined by decisions or regulations reaching back to the eighteenth and early nineteenth centuries. In all three countries, the question of medical privilege was to some extent contested, but the outcomes established by the early twentieth century differed considerably. Although British medical practitioners, when called as witnesses, repeatedly tried to maintain secrecy about private patient

⁷¹ 'Professional Secrecy of Doctors. Mr. Justice McCardie on Duty to Court', *The Times*, 19 July 1927, 11; E. Graham Little, 'Medical Privilege. Doctors and the Courts', *The Times*, 14 November 1927, 10; Ferguson, *Should A Doctor Tell?* (note 2), 130-131.

⁷² 'Foreign Letters: London: Law and Medicine', *JAMA* 90 (1928), 629.

⁷³ The widening of the bill's scope followed the argument that restriction to VD cases alone would indirectly confirm the disease whenever medical privilege was claimed. For details on Graham-Little's bills and their debate, see Ferguson, *Should A Doctor Tell?* (note 2), 138-153. Graham-Little's initiatives were also reported in the USA: 'Foreign Letters: London: Medical Secrecy', *JAMA* 90 (1928), 43; 'Foreign Letters: London: Rejection of Bill Concerning Professional Secrets', *JAMA* 108 (1937), 983.

⁷⁴ Sabine Michalowski, *Medical Confidentiality and Crime* (Aldershot and Burlington, VT: Ashgate 2003), 168.

details, judges compelled them to testify on the basis of legal precedent and the view that the evidence was material to the case concerned. In the USA, by the turn of the twentieth century about half of the states had followed the example of New York and had adopted statutes that restricted disclosure of patient information in court by their physician or surgeon, but exceptions were widely recognized.⁷⁵ This was especially true for criminal cases, such as illegal abortion, where the ethical duty of confidentiality was overridden by the interest in prosecution. In civil actions, there was considerable concern in the legal profession that the medical privilege was abused to commit fraud, especially in insurance cases. In Germany, doctors' entitlement, from the late 1870s onwards, to refuse to give evidence in criminal as well as civil cases did not prevent serious legal challenges which went right up to the Supreme Court. Eventually, however, medical secrecy was protected by the German courts on the basis of section 300 of the Reich Penal Code, unless there was a 'higher moral duty' that might justify disclosure, for example, warning the wife of a syphilitic husband of the danger of infection.

The different situations for doctors in British, American and German courts ultimately resulted from the different power relations between the medical and legal professions. Whereas in Britain the judiciary's interests dominated medical attempts to protect confidentiality, a more balanced relationship between the two professions in Germany led to recognition and confirmation of medical privilege in court. The United States, with about half of states adopting medical privilege and the other half still adhering to the English common law rule, seemed to reflect, apart from differences in the influence of the local medical profession, the outcome of efforts of traditionalist forces in law to withstand the modernizing example of the New York statute of 1828. Even in those American states that had enacted privilege for communications with physicians and surgeons there was considerable uncertainty about the specific circumstances in legal cases to which it applied or in which it might be regarded as implicitly waived.⁷⁶ In all three countries, secrecy was an important asset for the medical profession that set it apart from unlicensed practitioners. Besides confidentiality's importance for maintaining the trust between doctor and patient, a right to remain silent in court reflected a claim to a status that equalled

⁷⁵ By the late 1950s the proportion of American states that had adopted medical privilege had increased to about two-thirds. Austin V. Clifford, 'Privileged Communications between Physician and Patient, by Clinton Dewitt', *Indiana Law Journal* 35 (1959), 114.

⁷⁶ The Medicolegal Bureau of the American Medical Association advised in 1914: 'Because of the varying provisions of the law in different states, it is important that physicians do not take too much for granted, but that they secure legal advice, especially as to the law in their respective states.' 'Privileged Communications', *JAMA* 62 (1914), 1351. See also, from the legal point of view, E.B.P., 'Evidence: Privileged Communications to Physicians: Waiver', *California Law Review* 6 (1918), 300-302.

that of the legal profession. Finally, towards the end of the nineteenth century, recognition of an individual's general right to privacy began to provide an additional argument for protecting the medical secret against disclosure.